

96.4

AUM Student Health Services Immunization Record

Patient Name: Ellie Fleming

Birthdate: 8/11/2020

Allergies/Medical Alert: NKA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
meningococcal HEP B ACYW	12/3/2025	(L) Del Hail 1m		 NDC 49281-590-58 Meningococcal (Groups A, C, Y, W) Conjugate Vaccine MenQuadfi® single-dose (0.5 mL) Mfd by: Sanofi Pasteur Inc. 910266 Lot U8680AA EXP 2029/03			
Typhoid Other	12/3/2025	(R) Del Hail 1m	0.5mL	Sanofi	lot # 42A031m NDC: 49281-790-91 exp 12/27	10/3/19	WJS

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID							

Initials	Signature	Initials	Signature
WJS	WJS [Signature]		

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023

STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME Ellie Fleming

DATE OF BIRTH 08 / 11 / 20
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☒	☐
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☒	☐
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☒	☐
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☒	☐
11. Are you pregnant?	☐	☒	☐
12. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐
13. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☒	☐
14. Are you anxious about getting a shot today?	☒	☐	☐

FORM COMPLETED BY DAVID FLEMING (FATHER) DATE 12/3/25

FORM REVIEWED BY MB DATE 12/3/25

Did you bring your immunization record card with you? yes ☒ no ☐

It is important to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

