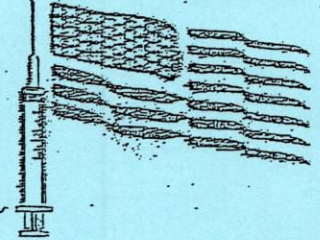


ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

Protect Our Future!



Name: _____

Date of birth: ____/____/____ Record # _____

Allergies: _____ Reactions: _____

History of Chickenpox? YES or NO If yes, date if known: _____

Immunize!

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf Abbr*	Lot Number	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr						
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Tdap					Tdap					0.5cc		IM	
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B (booster if needed)					Hep B							IM	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV					0.5cc		IM	
Hepatitis A					Hep A							IM	
Hepatitis A					Hep A							IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
MCV4					Mening							IM	
MPSV4					Mening							SQ	

* Manufacturers: M = Merck; S = Sanofi Pasteur; W = Wyeth; G = GlaxoSmithKline

** Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm, LD = Left Deltoid, RD = Right Deltoid

*** VIS Language given, if not English: _____

Patient name: Makenzie Anthony

Date of birth: 7 / 16 / 94
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Adults

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 additional questions must be asked. 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 vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

Form completed by: Makenzie Anthony

Date: 3-29-16

Form reviewed by: _____

Date: _____

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

It is important for you 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.

STATE OF ALABAMA

CERTIFICATE OF IMMUNIZATION

EXPIRATION DATE REQUIRED

(Date next vaccine is due)

6-8-2019

Month Day Year

MAKENZIE ANTHONY

07/16/1994

Name of Child

Date of Birth

Parent or Guardian

Diphtheria, Tetanus, and Pertussis Vaccine (Circle vaccine given.) A medical exemption (see reverse side) is required for children less than 7 years of age who are not given pertussis vaccine.

Dtap Acel	Dtap Acel	Dtap Acel	Dtap Acel	Dtap Acel	Tdap
09/23/1994	11/23/1994	01/27/1995	12/29/1998	04/21/1999	06/08/2009

Polio Vaccine (Circle vaccine given.)

IPV	IPV	IPV
09/23/1994	11/23/1994	04/21/1999

Measles, Mumps, Rubella (Circle vaccine given.)

MMR	MMR
04/21/1999	05/18/2000
Mo/Day/Year	Mo/Day/Year

Haemophilus influenzae Type b (Required for Day Care and Head Start only. Please record for historical information.)

Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year
09/23/1994	11/23/1994	01/27/1995	

Varicella Vaccine (Required for Day Care and Head Start September 2000. Required for Kindergarten entry Fall of 2001 and for a grade higher each successive year.)

In lieu of Varicella Vaccine

History of Chickenpox

Mo/Day/Year

Positive Varicella

Mo/Day/Year

Not required for school attendance. Please record for historical information. Do not expire this certificate for these vaccines.

Hepatitis B Vaccine

Mo/Day/Year	Mo/Day/Year	Mo/Day/Year
09/24/1994	09/23/1994	06/30/1995

Pneumococcal Conjugate Vaccine

Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year

Other Specify Vaccine (not to include TB skin test)

Vaccine	Date	Vaccine	Date	Vaccine	Date

Catherine L. Hodges

Authorized Medical Signature

6/8/09

Date

PARTNERS IN PEDIATRICS
8160 SEATON PLACE
MONTGOMERY, AL 36116

Name of Clinic