

**AUM Student Health Services
Immunization Record**

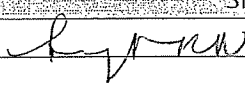
Patient Name: Myla Stafford

Birthdate: _____

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	Visit Date	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B							
Other							

	Date Given	Date Read	Results	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	1/31/18	2/2/18	2mm	SP	C5471AA	(2) forearm	AM

Initials	Signature	Initials	Signature
AM			

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