

**AU Adult Screening and Immunization Documentation Form
2009 H1N1 Influenza Monovalent Vaccination Program**

224.1

Patient Information:	
Last Name: <u>Bagents</u>	First Name: <u>Courtney</u> Date of Birth: <u>04-24-1987</u>
AU Banner ID Number: <u>50541758</u>	E-mail Address: <u>cbagents@alum.edu</u> Phone #: <u>334-315-2420</u>

Please Carefully Read and Answer the Following Questions: (circle your answer)

1	Are you between the ages of 10 and 49 years?	☒ Yes	☐ No
2	If you are between the ages of 10 and 17 years, do you take aspirin or aspirin containing medications daily? (Please inform the healthcare provider of any medications you take daily so we can carefully screen for any aspirin containing products)	☒ Yes	☐ No
3	Have you received the 2009-2010 seasonal influenza vaccine? If so, did you receive the nasal _____ or injection _____. How long has it been since this vaccination? _____ (days)	☐ Yes	☒ No
4	Do you currently feel sick or have a fever?	☐ Yes	☒ No
5	Are you taking any prescription medications to prevent or treat influenza? (Amantadine, Rimantidine, Tamiflu®, Relenza®) Have you taken any antivirals in the past 48 hours?	☐ Yes	☒ No
6	Have you ever had a serious reaction to the flu vaccine? Please describe: _____	☐ Yes	☒ No
7	Do you have an allergy to any of the following: eggs, chicken or egg protein, gentamicin, gelatin, arginine, neomycin, polymyxin B, thimerosal, formaldehyde? List any allergies: <u>Sulfa-Drugs</u>	☐ Yes	☒ No
8	Do you have a chronic health problem such as: heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorder? <u>Thyroid disorder (hypo)</u>	☒ Yes	☐ No
9	Do you have an active neurological disease (a disease of the brain, nervous system, etc.)?	☐ Yes	☒ No
10	Do you have a history of Guillain-Barre Syndrome (GBS)?	☐ Yes	☒ No
11	Has your doctor ever told you that you have an immune system disorder? Are you currently taking long-term corticosteroids (prednisone, methylprednisolone, etc.); immunosuppressants; chemotherapy; biologic immune modulating medications such as Remicade®, Enbrel®, Humira®, etc? If you have an inflammatory condition such as arthritis, asthma, psoriasis, inflammatory intestinal disease, etc.	☐ Yes	☒ No
Please tell the healthcare provider now.			
12	Do you have HIV, cancer, or have you received an organ transplant?	☐ Yes	☒ No
13	Do you live with, care for, or have close contact with anyone who is severely immunocompromised or someone who has to be in protective environment (such as transplant patients)? <u>Clinicals</u>	☒ Yes	☒ No
14	Have you received any vaccines in the past 30 days or do you plan to receive any vaccines in the next 4 weeks?	☐ Yes	☒ No
15	Is there any chance that you are currently pregnant?	☐ Yes	☒ No
16	Please list all of the medications that you currently take for any disease state (so the healthcare provider administering the vaccine can conduct a medication screening to ensure you are a candidate)? <u>Synthroid 125mcg</u> <u>Birth-control</u>		

"I have read (or have had explained to me) the information in the 2009 H1N1 Influenza Monovalent Information Statement (VIS). I have also had an opportunity to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine, and I consent to receive the vaccine. I have also been provided a copy of the Auburn University Pharmaceutical Care Center (AUPCC) privacy policy for my review before vaccine administration and offered a copy for my records."

Signature: Courtney D. Bagents Date: 11-11-09

ASSESSMENT BY IMMUNIZATION CERTIFIED HEALTHCARE PROVIDER:

☒ Give <u>injectable</u> H1N1 flu vaccine today ☐ Give <u>intranasal</u> Live H1N1 flu vaccine today ☐ Do NOT give either H1N1 vaccine today	Vaccine Information Statement (VIS) Provided: ☒ Inactivated, H1N1 Influenza Monovalent Vaccine ☐ Live, H1N1 Influenza Monovalent Vaccine Interviewer's Signature: <u>Rachel Jay</u> Date: <u>11/11/09</u>
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DOCUMENTATION OF VACCINE ADMINISTRATION

Live Intranasal H1N1 Influenza (MedImmune) NDC# 66019-200-10 Lot #: 500757 Expiration Date: January 25, 2010 Dose: 0.2 ml Route: Intranasal Administered By: <u>[Signature]</u> Date: <u>November 11, 2009</u>	Inactivated H1N1 Influenza: Manufacturer: (circle) <u>Sanofi-Pasteur</u> Novartis CSL NDC# _____ Lot#: <u>UPO 22A11</u> Exp Date: <u>05 APR 11</u> Dose: 0.5 ml Route: IM Site: <u>Left/Right Deltoid</u> Preceptor: <u>[Signature]</u>
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Student's Name

Courtney Bagenti

Required Immunizations

1. Tetanus-Diphtheria(Td), Adult-Type Date 10/4/2002 Dosage Td0.5ml
(Completed series, booster every 10 years)
2. MMR Vaccine (Those born before 1957 are exempt) Date 5/7/1992 Dosage _____
(Must be one dose after 1990)
3. Hepatitis B Vaccine: Initial Dose Date 6/23/08 Dosage _____
Second Dose Date 7/28/08 Dosage 1ml
Third Dose Date _____ Dosage _____
4. The varicella vaccine for chickenpox is required if antibody levels are $< 1:8$.
Varicella vaccine: Initial Dose Date _____ Dosage _____
Second Dose Date _____ Dosage _____

Required Diagnostic Studies

1. Varicella Titer (if no prior history of the vaccine) Date 6/23/08 Result 4.05 ($> 1:10$)
2. Hepatitis B Titer (if no available documentation of the vaccine) Date _____ Results _____
3. MMR Titers **If no available documentation of the vaccine exists, titers for measles, mumps, and rubella will be accepted and are preferred.
Measles (Rubeola) Date _____ Results _____
Mumps Date _____ Results _____
Rubella Date _____ Results _____

NOTE: Students must possess the functional ability to perform the skills and demonstrate the behaviors required of a professional nurse. These abilities include, but are not limited to, (a) adequate vision, such as that required to observe changes in physical conditions, to read small print on labels and reports, and to discern subtle changes in color; (b) adequate hearing, such as that required to distinguish muted sounds through a stethoscope; (c) fine motor skills and manual dexterity, such as required to handle small, delicate equipment; (d) strength to turn and assist with lifting adults, and to lift and carry children; (e) the mobility to perform skills and respond quickly in emergency situations; (f) the ability to communicate and interact effectively with others, verbally and in writing; and (g) the ability to detect odors.

Are there any conditions, concerns, or treatments that may affect the ability of this student to meet these program requirements? () YES (X) NO

DATE OF EXAM

6/23/2008

Health Care Provider's Signature

RAGHU MUKKAMALA M-D

Health Care Provider's Name (Print)

Address

1722 Pine Street Suite 309

City, State, and Zip Code

Mo Abq New Az 36106

MONTGOMERY CO. HEALTH DEPT.(MONTGOMERY)**COURTNEY BAGENTS - (611106638)****D.O.B. 4/24/1987****Immunization History
Combination Shot Breakout**

Date Given	Vaccine Type	Update Date
DTP/DT/Td SERIES		
10/04/2002	TETANUS DIPHTHERIA (ADULT)	07/28/2008
MMR SERIES		
05/07/1992	MEASLES, MUMPS, RUBELLA	07/28/2008
HEP B SERIES		
06/25/2008	HEPATITIS B	06/25/2008
07/28/2008	HEPATITIS B	07/28/2008
12/30/2008	HEPATITIS B	12/30/2008
OTHER		
08/21/2008	HUMAN PAPILLOMAVIRUS, QUAD (6,11,16,18)	08/31/2008
10/03/2008	INACTIVATED INFLUENZA -TIV	10/19/2008
10/22/2008	HUMAN PAPILLOMAVIRUS, QUAD (6,11,16,18)	11/02/2008

**Montgomery County Health Department
Medical Records
3060 Mobile Highway
Montgomery, AL 36108
Phone: (334) 293-6400**

**AUM NURSING CARE CENTER
IMMUNIZATION RECORD**

PATIENT NAME: Courtney Bagents

BIRTHDATE: 4/24/87

ALLERGIES/MEDICAL ALERT: Sulfa

IMMUNIZATION	DATE	SITE	DOSE	MFR	LOT#	COMMENTS	VIS/DATE	INITIALS
DPT								
DPaT								
DT								
Td BOOSTER								
MMR								
MR								
HIB								
HEPATITS B								
OTHER								

TUBERCULIN TESTING PPD (MANTOUX) 0.1ml ID	DATE GIVEN	DATE READ	RESULTS	MFR	LOT#	COMMENTS	INITIALS
	6/30/09	7/2/09	0mm	Sanofi	C3060AA	(L) forearm	AM

INITIALS	SIGNATURE	INITIALS	SIGNATURE
AM	[Signature]		