

**AUM Student Health Services
Immunization Record**

Patient Name: Beak, m: n

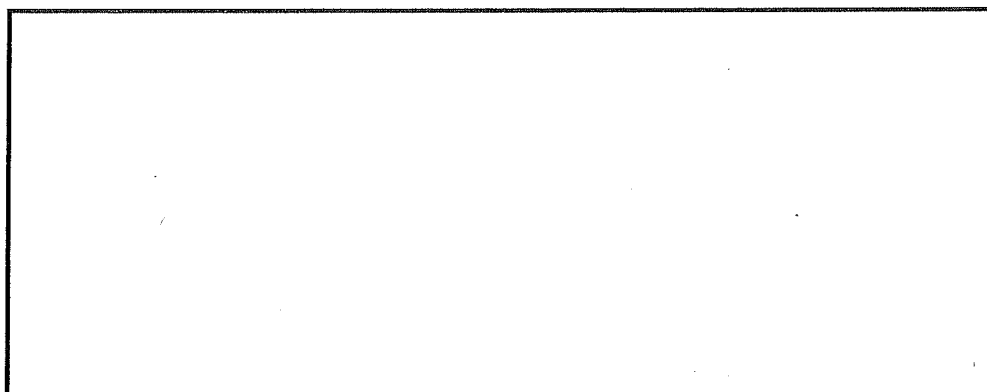
Birthdate: 3-1-96

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	Visit Date	Initials
Tdap	1/12/18	LD	0.5cc	Adacel® NDC 49281-400-58 L: U58T9AA E: 13MAR20		2/15	AM
Td Booster							
MMR							
HEP A							
HEP B							
Other							

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	1-3-18	1/5/18	0mm	Smith Purshouse	C5L54AA	Ⓢ forearm	AM

Initials	Signature	Initials	Signature
AM	L. Stewart, RNPP		



STAMP ABOVE

No. 울산남구 2017 - 24

Certificate of Tuberculin skin test

Name : BEAK MIN JI

Sex : ☐Male, ☒Female

Date of Birth(Mo/Day/Yr) : March/01/1996

Country of Birth : Republic of Korea

Address : 203-2401, 82. Daeam-ro, Nam-gu, Ulsan, Republic of Korea

Phone Number : 82-10-3165-0430

This is to certify that above named person's examination as below.

PPD Test(Mantoux) : Date given : 12/26/2017 Date read: 12/29/2017

Results : NEGATIVE Site of reaction : 0.0 mm

Chest X-ray Examination : Date : _____ Results : _____

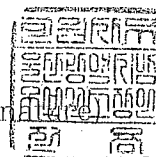
Certify that the above information is correct

2017 . 12. 29.

Physician : Name Seo yongjun

Licence # 94335

Provider organization : Ulsan Nam-gu Public Health Center (signature)



예방접종증명서
Certificate of Immunization

[illegible]

「감염병의 예방 및 관리에 관한 법률」 제27조 및 같은 법 시행규칙 제22조에 따라 위와 같이 예방접종하였음을 증명합니다.

2017년 12월 26일
Year month day

The head of Nam-gu



Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
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 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 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?	☐	☒	☐
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 _____

Beak, Mm Ji

DATE _____

01/12/2018

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.