

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Donna Garrison
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? <i>allergic to Vicodin</i>	☒	☐	☐
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 Donna Garrison DATE 8/7/18
FORM REVIEWED BY [Signature] CRNP DATE 8/7/18

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.

AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 2/15/18 Name Donna Garrison

1. What is the reason for your visit today travel to Zambia this summer
2. List allergies you have to medicines, foods or iodine: vicadin
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): Multivitamin, Amitriptyline
4. Have you had any of the following: (circle if this applies to you);
Heart disease _____
Kidney disease _____
Stomach/Gastrointestinal disease _____
Diabetes/sugar _____
5. Are you immunocompromised? (Is there a problem with your immune system) Yes _____ Not ✓
Thymus disorder (Myasthenia gravis, thymoma, thymectomy) _____
Spleen removed _____
Transplant recipient _____
Cirrhosis of the liver _____
Cancer _____
HIV _____
6. How often do you drink beer, wine, wine cooler, or liquor? (Please circle)
Never / Rarely / 1-2 times a week / 3-4 times a week / 5 or more times a week
7. Where are you going on your trip? Zambia
8. How long is your trip? Months _____ Days 10
9. When are you leaving on your trip? June 25, 2018

FOR FEMALES ONLY

- A. Date of your last period? 1/17/18 Have you had a hysterectomy? YES _____ NO ✓
- B. Are you currently pregnant? YES _____ NO ✓
What is your due date? _____
- C. Do you plan to become pregnant in the next 3 months? YES _____ NO ✓
- D. Are you breastfeeding? YES _____ NO ✓

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Donna Garrison

DATE OF BIRTH 2 / 23 / 84
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 Donna Garrison

DATE 2/15/18

FORM REVIEWED BY [Signature]

DATE 2/15/18

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.

ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: AUM SHS

Name: Donna Garrison

Date of Birth: 2/23/84 Record #: _____

Allergies: Vicodin Reactions: _____

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

Vaccine	Date Admin			Age at the time	VIS Form Given			Manu* Abbr*	Lot#	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr						
Td					Td				EF773 09/29/18	0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					1m 0.5cc		IM	
Td					Td					0.5cc		IM	
Tdap					Tdap					0.5cc		IM	
Hep B + HepA	2	15	18		Hep B	7	16	GSK		1.0	LD	IM	AM
Hep B + HepA	3	15	18		Hep B	7	16	GSK	EF773 09/29/18		LD	IM	AM
Hep B + HepA	8	7	18		Hep B	7	16	GSK			LD	IM	MA
Hep B (booster if needed)					Hep B							IM	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
Varicella					Var							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: _____

Medicines for the Prevention of Malaria While Traveling

Atovaquone-Proguanil (Malarone™)

What is atovaquone-proguanil?

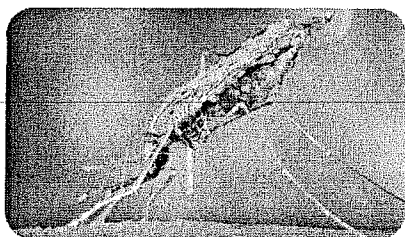
Atovaquone-proguanil is a combination of two drugs, atovaquone and proguanil, in a single tablet. It is available in the United States by prescription only. It is sold under the brand name Malarone and it is also sold as a generic medicine in two sizes:

Adult tablet: 250mg atovaquone plus 100mg proguanil

Pediatric tablet: 62.5mg atovaquone plus 25mg proguanil

Atovaquone-proguanil can be prescribed for either prevention or treatment of malaria.

This fact sheet provides information about its use for the prevention of malaria infection associated with travel.



Who can take atovaquone-proguanil?

Atovaquone-proguanil can be prescribed to adults and children who weigh at least 11 pounds (5 kg).

Who should not take atovaquone-proguanil?

Pregnant women, women who are nursing infants less than 5kg, or infants who weigh less than 5kg should not take atovaquone-proguanil. Also, people with severe kidney disease should not take atovaquone-proguanil.

How should I take atovaquone-proguanil?

Both adults and children should take one dose of atovaquone-proguanil per day starting a day or two before traveling to the area where malaria transmission occurs. They should take one dose per day while there, and for 7 consecutive days after leaving. In rare instances (such as if you switched to atovaquone-proguanil from another malaria medicine) your doctor may instruct you to take it for a longer period of time.

The daily dosage for adults is a single adult tablet.

The daily dosage for children depends on their weight. The list below shows the daily dose for children based on their weight:

5–8 kg children should take a ½ pediatric tablet daily,

> 8–10 kg: ¾ pediatric tablet daily

> 10–20 kg: 1 pediatric tablet daily

> 20–30 kg: 2 pediatric tablets daily

> 30–40 kg: 3 pediatric tablets daily

> 40 kg: 1 adult tablet daily

Atovaquone-proguanil should be taken with food or a milky drink.

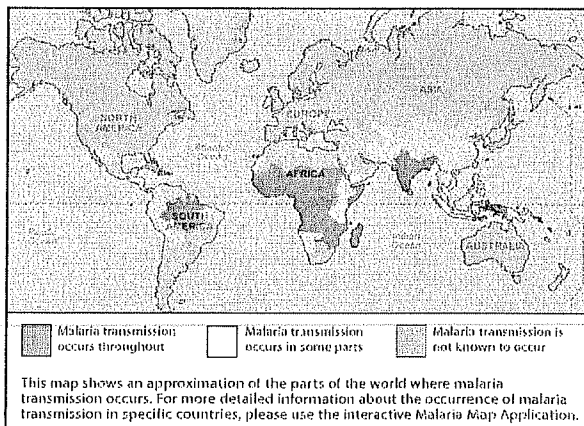
Where can I buy atovaquone-proguanil?

Antimalarial drugs are available in the United States by prescription only. Medicines should be obtained at a pharmacy before travel rather than in the destination country. Buying medications abroad has its risks: the drugs could be of poor quality, contaminated, or counterfeit and not protect you against malaria.

In what parts of the world can atovaquone-proguanil be used for prevention of malaria in travelers?

Currently atovaquone-proguanil can be taken in any part of the world where malaria occurs.

CDC keeps track of all the places in the world where malaria transmission occurs and the malaria drugs that are recommended for use in each place. This information can be found using the malaria map on the CDC website: <http://www.cdc.gov/malaria/map/index.html>.





Auburn University Montgomery
Student Health Services

Hepatitis A and B Reminder

Date: 8/3/18

Dear Mrs. Garrison:

Your final Hepatitis A and B (Twinrix) vaccine is due on 8/15/18.
Please call the Nursing Care Center for an appointment as soon as possible,
at 244-3281 to continue receiving your immunization as scheduled.

In order for your immunization against Hepatitis A and B to be continued
within the recommended schedule, you must have your final dose by
8/30/18.

Thank you for allowing us to participate in the protection of your good
health.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Amy Morris'.

Amy Morris, M.P.A., R.N., B.C.
AUM-Nursing Care Center



Hepatitis A and B Reminder

Date: 3/2/18

Dear Mrs. Garrison:

Your second Hepatitis A and B (Twinrix) vaccine is due on March 15, 2018. Please call the Student Health Center at Auburn Montgomery for an appointment as soon as possible at 244-3281, to continue receiving your immunization as scheduled.

In order to stay within the recommended schedule, you should receive your next dose by March 29, 2018.

Thank you for allowing us to participate in the protection of your good health.

Sincerely,

Amy Morris, RN-BC *AM*

Amy Morris, RN-BC
AUM-Nursing Care Center

Information for Healthcare Professionals about the Screening Checklist for Contraindications to Vaccines for Adults

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references listed at the end.

1. Are you sick today? [all vaccines]

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events.¹ However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Do you have allergies to medications, food, a vaccine component, or latex? [all vaccines]

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component. For information on vaccines supplied in vials or syringes containing latex, see reference 2; for an extensive list of vaccine components, see reference 3.

People with egg allergy of any severity can receive any recommended influenza vaccine (i.e., any IIV or RIV) that is otherwise appropriate for the patient's age. For people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress), or who required epinephrine or another emergency medical intervention, the vaccine should be administered in a medical setting, such as a clinic, health department, or physician office. Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.⁴

3. Have you ever had a serious reaction after receiving a vaccination? [all vaccines]

History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses.¹ Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

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? [MMR, LAIV]

A history of thrombocytopenia or thrombocytopenic purpura is a precaution to MMR vaccine. The safety of intranasal live attenuated influenza vaccine (LAIV) in people with these conditions has not been established. These conditions, including asthma in adults, should be considered precautions for the use of LAIV.

5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? [LAIV, MMR, VAR, ZOS]

Live virus vaccines (e.g., LAIV, measles-mumps-rubella [MMR], varicella [VAR], zoster [ZOS]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/ μ L. Immunosuppressed people should not receive LAIV. For details, consult the ACIP recommendations.^{4,5,6}

6. In the past 3 months, have you taken medications that affect your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? [LAIV, MMR, VAR, ZOS]

Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement.^{1,5} Some immune mediator and immune modulator drugs (especially the antitumor-necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. The use of live vaccines should be avoided in persons taking these drugs (MMWR 2011;60 [RR-2]:23). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7. LAIV can be given only to healthy non-pregnant people ages 2 through 49 years.

NOTE: Live attenuated influenza vaccine (LAIV4; FluMist), is not recommended by CDC's Advisory Committee on Immunization Practices for use in the U.S. during the 2017–18 influenza season.

7. Have you had a seizure or a brain or other nervous system problem? [influenza, Td/Tdap]

Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (IIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with IIV if at increased risk for severe influenza complications.

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? [LAIV, MMR, VAR, ZOS]

Certain live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines.¹

9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? [HPV, IPV, MMR, LAIV, VAR, ZOS]

Live virus vaccines (e.g., MMR, VAR, ZOS, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of exposure is imminent and immediate protection is needed (e.g., travel to endemic areas). Inactivated influenza vaccine and Tdap are both recommended during pregnancy. Both vaccines may be given at any time during pregnancy but the preferred time for Tdap administration is at 27–36 weeks' gestation. HPV vaccine is not recommended during pregnancy.^{1,4,5,6,8,9}

10. Have you received any vaccinations in the past 4 weeks? [LAIV, MMR, VAR, yellow fever, ZOS]

People who were given either LAIV or an injectable live virus vaccine (e.g., MMR, VAR, ZOS, yellow fever) should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously.

REFERENCES

1. CDC. General best practice guidelines for immunization. Best Practices Guidance of the Advisory Committee on Immunization Practices (ACIP) at www.cdc.gov/vaccines/hcp/acip-recs/downloads/general-recs.pdf.
2. Latex in Vaccine Packaging: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf.
3. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/exipient-table-2.pdf.
4. CDC. Prevention and control of seasonal influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, 2017–18 Influenza Season at www.cdc.gov/mmwr/volumes/66/jr/pdfs/rr6602.pdf.
5. CDC. Measles, mumps, and rubella – vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. MMWR 1998; 47 (RR-8).
6. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. MMWR 2007; 56 (RR-4).
7. Tomblyn M, Einsele H, et al. Guidelines for preventing infectious complications among hematopoietic stem cell transplant recipients: a global perspective. Biol Blood Marrow Transplant 15:1143–1238; 2009 at www.cdc.gov/vaccines/pubs/hematocell-transplants.htm.
8. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. MMWR 2001; 50 (49).
9. CDC. Updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) in pregnant women: Recommendations of the ACIP. MMWR 2012; 62 (7):131–4.

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: _____ TIME: _____ PT. HISTORY REVIEWED / UPDATED _____ / _____ / _____
 PATIENT NAME: _____ DOB: _____ AGE: _____
 PRESENT COMPLAINT: _____

EDUCATIONS:						LMP: _____
Temp	Pulse	Respn	B/P	HT	WT	Allergies

INITIAL VISIT

RETURN VISIT

Skin
Sinuses
Ears
Eyes
Nose
Throat
Neck/ Back
Heart
Lungs
Abdomen
GU/GI
Extremities

DIAGNOSIS: _____ _____ _____ _____	<u>TESTS</u> _____ _____ _____	<u>RESULTS</u> _____ _____ _____
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PLAN: _____

CALL BACK: _____

PRACTITIONER SIGNATURE: _____ STAFF SIGNATURE: _____

AUDIT DATE: _____ COMMENTS: _____

PHYSICIAN SIGNATURE: _____