

**AUM Student Health Services
Immunization Record**

Patient Name: EDWARD WILLIAMS

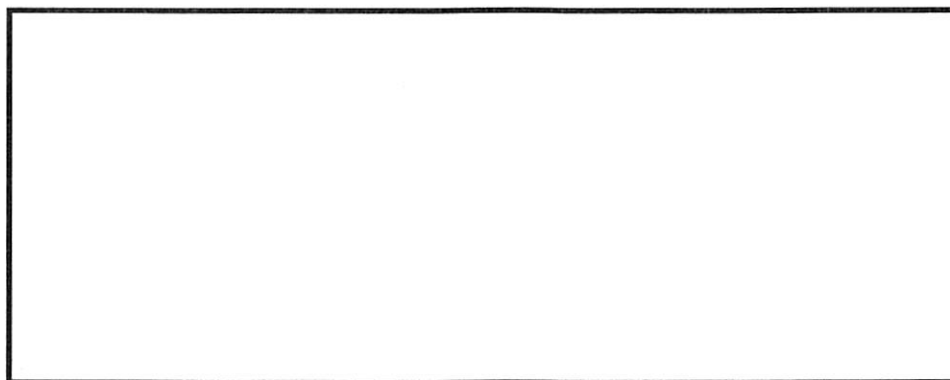
Birthdate: 12/19/1942

Allergies/Medical Alert: Latex

Immunization	Date	Site	Dose	MFR	Comments	Visit Date	Initials
Tdap					LOT 299X2 EXP 01/24/22		
Td Booster					NDC 55160-825-03 Hepatitis A Vaccine HAVRIX®		
MMR					1440 ELU/mL Mfg. by GlaxoSmithKline Biologics		
HEP A	#2 9/5/19	RD	1.0cc			7/16	AM
HEP B							
Other							

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials

Initials	Signature	Initials	Signature
PM	fyoon		



STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME EDWARD R. WILLIAMS
DATE OF BIRTH 12/19/1942
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., <u>diabetes</u>), 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?	☐	☐	☐ N/A
10. Have you received any vaccinations in the past 4 weeks?	☒	☐	☐

FORM COMPLETED BY EDWARD R WILLIAMS DATE 9-05-2019

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.

COLUMBUS DEPT OF PUBLIC HEALTH
Immunization History Date Printed: 09/05/2019 Time:10:23:53

Patient Name : WILLIAMS , EDWARD R
14239 GA HWY 219
WEST POINT, GA 31833
Birthdate : 12/19/1942
Home Phone : 706-663-4072

Patient Number : 192981
Chart Number :
Race: W Ethnicity: N Sex: M
Age: 76 Yr 8 Months 17 Days
Business Phone :
Prim Language : E

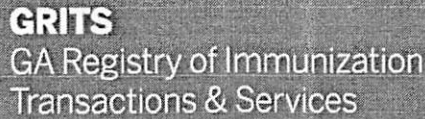
Rel Name : ,
Health Center: COLUMBUS DEPT OF PUBLIC HEALTH
2100 COMER AVENUE
COLUMBUS GA 31904-8725

Phone : 706-321-6300

Prior Approval Expiration:

I M M U N I Z A T I O N S A S O F 09/05/2019

FLU VACCINE: 12/17/2009-01 10/12/2016-02 08/21/2017-03 09/27/2018-04 09/03/2019 (WD Pharm
AC/AL -
HEP A: 01/19/2010-01
INJ POLIO: 01/19/2010-01
PREVNAR 13: 01/17/2019-01
ADULT TD: 02/17/2004-01 09/04/2019 WINN DIXIE PHARMACY (AC, AL)
TYPHOID: 01/19/2010-01
mmRI 09/03/2019 WINN DIXIE (AC, AL)



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