

CLINIC:

Date of birth. 04/16/2013 Record #

Reactions:

Immunize!

* 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:

***Provider Information

[illegible]

Tuberculin Test

[illegible]

Titer Test Results for Non Susceptibility (IgM)

Date			Disease	✓ Results		Notes
Mo	Day	Yr		Neg	Pos	

[illegible]

Patient name:

Cherish Besong

Date of birth:

04/16/2013
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child 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. Is the child sick today?	☐	☒	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☒	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☒	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had <u>wheezing</u> or asthma in the past 12 months?	☒	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☒	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☒	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐	☒	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☒	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☒	☐

She has had respiratory problems w/ but not asthma a cold mostly

Form completed by:

Quasire Takang

Date:

3/8/14

Form reviewed by:

Date:

Did you bring your child's immunization record card with you?

yes ☐no ☒

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

Auburn Montgomery Student Health Center

Consent for Yellow Fever Vaccine

I hereby give my consent to be vaccinated against Yellow Fever. I have been given information and an opportunity to ask questions about the vaccine and the risks involved. All my questions have been answered to my satisfaction. I have been informed that persons are at an increased risk for a reaction if they are:

- 1) Allergic to a component to the vaccine;
- 2) Over age 60;
- 3) Have thymus disorder or disease; or
- 4) Are immunocompromised (by HIV, cancer or medications, etc.).

Further, pregnant and breast-feeding women should not take the vaccine without consulting their OB-GYN or pediatrician. I understand that I may consult with my private physician about the vaccine should I desire to do so. I understand that as with all medical treatments, there is no guarantee that I will not experience an adverse effect.

Cherish Besong

Printed Name (Individual to receive vaccine)

she is a child cannot sign
Valery mother

(Signature) Individual to receive vaccine)

03/18/16

Date

Witness (Licensed personnel)

03/18/16

Date