

AUM Student Health Services

Immunization Record

Patient Name: Michelle Jones

Birthdate: 6-25-76

Allergies/Medical Alert: Tamiflu

Immunization	Date	Site	Dose	MFR	Comments	V.I.S.	Initials
Tdap	6/1/21	L. Del	0.5ml	61410-842-43	Lot: 45496 EXP: 9/1/22 NDV: 55410-842-43		LB
Td Booster							
MMR	6/8/21	Rt. arm posterior			1 Single-dose 0.5-mL Vial MEASLES, MUMPS, AND RUBELLA VIRUS VACCINE LIVE M-M-R® II Rz only Lot Exp. T013724 2022APR21	SQ	LB
HEP A							
HEP B							
Other							

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	6/1/2021	6-3-21	0	Smith	C5751AA	L. FA	LB

Initials	Signature	Initials	Signature
LB	J. L. Moore		

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36114-0223

STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME

Michelle Jones

DATE OF BIRTH

6/25/76
month day year

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. Does the child have lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? 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 wheezing 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 or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐	☒	☐
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; 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?	☐	☒	☐

FORM COMPLETED BY

Michelle Jones

DATE

6/1/21

FORM REVIEWED BY

Andrea Margette

DATE

6-1-21

Did you bring your 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.



Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (4/19)