

**AUM Student Health Services
Immunization Record**

Patient Name: Lauren Knierim

Birthdate: 12/15/1983

Allergies/Medical Alert: NKA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap	5/14/2022	Cheek	0.5 mL			8/14/21	JS
		Im	NOC 9180-942-43 Totanes Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX	0.5 mL			
Td Booster			Made by GlaxoSmithKline Biologicals	496018			
MMR							
HEP A							
HEP B							
Other							

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	5/14/2022	5-6-22	0	Smith	CS 605AA	exp 3/17/23 (GFA)	JS

Initials	Signature	Initials	Signature
JS	JS		

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023

STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Lauren Knierim
DATE OF BIRTH 12 / 5 / 1943
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 Lauren Knierim DATE 5/4/22
FORM REVIEWED BY MS [signature] RN 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.

immunization
action coalition



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/p4065.pdf • Item #P4065 (4/18)



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Lauren Kniehm

Date of Birth: 12/5/83

Student Number: _____

Please mark "yes" or "no" to the following questions.

YES NO

1. Do you have a cough that has lasted longer than 3 weeks?		X
2. Have you coughed up blood or mucus?		X
3. Have you had fever, chills, or night sweats?		X
4. Have you had unintentional weight loss?		X
5. Have you been feeling very tired?		X
6. Have you lost your appetite?		X
7. Have you ever had a positive TB skin test result or Positive interferon gamma release assay (IGRA) result? If so, when?		X
8. Have you ever had an abnormal chest x-ray?		X
9. Have you recently had the mucus coughed up tested for TB?		X
10. Have you ever been told you had TB or latent TB?		X
11. Have you ever taken medicine for TB?		X
12. Have you ever lived with or had close contact with someone who had TB?		X
13. Do you currently have a rash on either forearm?		X
14. Are you immunocompromised? (Steroids, chemotherapy, or other?)		X
15. Have you received a live vaccine in the past 30 days?		X

All TB skin test and Chest x-rays must be performed in the U.S. to be valid.

I attest the above is true and accurate to the best of my knowledge.

Patient Signature: [Signature]

Date: 5/4/22

Provider Signature: [Signature]

Date: 5/4/2022



Patient Information	Specimen Information	Client Information
KNIERIM, LAUREN DOB: 12/05/1983 AGE: 38 Gender: F Phone: NG Patient ID: 4772	Specimen: AL748185R Requisition: 7108525 Lab Ref #: 00782290 Collected: 05/04/2022 / 08:46 CDT Received: 05/05/2022 / 01:36 CDT Reported: 05/05/2022 / 14:19 CDT	Client #: 49100638 QATL0000 BARTON, LINDSEY AUM NURSING CARE CENTER 7461 EAST DRIVE #102 MONTGOMERY, AL 36117

PROVIDER: BICKNELL MIRANDA

Test Name	In Range	Out Of Range	Reference Range	Lab
VARICELLA ZOSTER VIRUS ANTIBODY (IGG) Index	1526.00		index	AT
	Interpretation			
<135.00	Negative - Antibody not detected			
135.00 - 164.99	Equivocal			
> or = 165.00	Positive - Antibody detected			

A positive result indicates that the patient has antibody to VZV but does not differentiate between an active or past infection. The clinical diagnosis must be interpreted in conjunction with the clinical signs and symptoms of the patient. This assay reliably measures immunity due to previous infection but may not be sensitive enough to detect antibodies induced by vaccination. Thus, a negative result in a vaccinated individual does not necessarily indicate susceptibility to VZV infection. A more sensitive test for vaccination-induced immunity is Varicella Zoster Virus Antibody Immunity Screen, ACIF.

PERFORMING SITE:

AT QUEST DIAGNOSTICS-ATLANTA, 1777 MONTREAL CIRCLE, TUCKER, GA 30084-6802 Laboratory Director: ANDREW N. YOUNG, MD, PhD, CLIA: 11D0255931