

Alabama Department of Public Health

CERTIFICATE OF IMMUNIZATION

02/20/2025

Date of Expiration

(Next Required Immunization)

EVAN ELIZABETH SHEPARD

Child's Name (first, middle, last)

01/16/1998

Birthdate

Parent/Guardian Name (first, middle, last)

Unless Specifically exempted by law, Alabama law (code of Alabama 1975, Section 16-30-4) requires a certificate on file for each child in attendance in all schools and licensed child care facilities in Alabama. Instructions for this form and immunization requirements by age are detailed via the ADPH web site at www.adph.org/immunization

Vaccine	DOSE1 DATE MM DD YY	DOSE2 DATE MM DD YY	DOSE3 DATE MM DD YY	DOSE4 DATE MM DD YY	DOSE5 DATE MM DD YY	DOSE6 DATE MM DD YY	Total Doses	Confirmed Lab MM YY	History MM YY
Required Vaccines for School or Child Care Attendance									
DTP,DTaP,DT	DTAP 03/25/98	DTAP UNS 05/29/98	DTAP UNS 07/27/98	DTAP UNS 07/16/99	DTAP 01/23/03				
TD									
Tdap	TDAP 02/20/15								
IPV,OPV	OPV 03/25/98	OPV 05/29/98	OPV 07/16/99	IPV 02/20/02					
Hib (Under Age 5)	HIB UNS 03/25/98	HIB UNS 05/29/98	HIB UNS 07/27/98	HIB UNS 02/04/99					
Measles	MMR 04/26/99	MMR 01/23/03							
Mumps	MMR 04/26/99	MMR 01/23/03							
Rubella	MMR 04/26/99	MMR 01/23/03							
PCV									
Varicella									

Recommended Vaccines									
HepA	HEP A 02/20/15								
HepB	HEP B 02/24/98	HEP B 03/25/98	HEP B 10/28/98						
HPV									
MCV or MPSV									
Rotavirus									

NOTES:

A licensed physician or qualified employee of the Alabama Dept. of Public Health is responsible for the content of this certificate. All dates must include in the month, day, and year. In cases of history of disease or laboratory confirmation, the month and year of infection, or test must be filled in the appropriate box(es).

The certificate is NOT valid without the name and birth date of the child, date of expiration, legible name and address of the physician or health department, certified by signature, and the date of issue. A school or facility official is responsible for keeping a current valid Certificate on the file for each child in attendance. When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian.

Clinic Name : PEDIATRIC HEALTHCARE LLC

Address: 4700 WOODMERE BLVD
MONTGOMERY 36106

Telephone #: (334)273-9700

Certified by (Signature)

2/20/2015
Date of Issue

***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: Evan Shepard

Date of birth: 2/24/15
(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 between the ages of 2 and 4 years, 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 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?	☒	☐	☐

Form completed by: Evan Shepard
Form reviewed by: [Signature]

Date: 2-24-15
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.

Evan Shepard

Printed Name (Individual to receive vaccine)

Evan Shepard

(Signature) Individual to receive vaccine)

2-24-15

Date

[Signature]

Witness (Licensed personnel)

2/24/15

Date