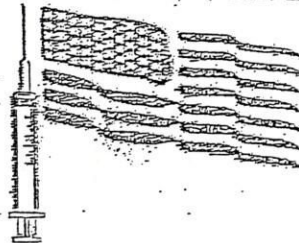


ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

Protect Our Future!



Name: Maurice Brown

Date of birth: 12/17/79 Record #

Allergies: Reactions:

History of Chickenpox? YES or NO If yes, date if known:

Immunize!

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf Abbr*	Dose	Admin Site**	Route	Provider Initials*** or Name
	Mo	Day	Yr		Type	Mo	Yr					
Td					Td			Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX®	0.5cc		IM	7C423 05/06/18 NOC 58160-915-43 Hepatitis A & Hepatitis B (Recombinant) Vaccine TWINRIX® 1 mL 474193 AM
Td					Td				0.5cc		IM	
Td					Td				0.5cc		IM	
Td					Td				0.5cc		IM	
Tdap	8	15	16		Tdap	2	15	KSK	0.5cc	LT	IM	AM
Hep B + Hep A	8	15	16		Hep B	7	16	KSK	1.0	RD	IM	AM
Hep B											IM	
Hep B											IM	
Hep B (booster if needed)											IM	
MMR Rubella Rubeola	8	15	16								LA SQ	AM
MMR Rubella Rubeola					MMR				0.5cc		SQ	
Varicella					Var				0.5cc		SQ	
Varicella					Var				0.5cc		SQ	
IPV	8	15	16		Polio	7	16	Merck M1205-1	0.5cc	RD	IM	AM
IPV					Polio				0.5cc		SQ	
IPV					Polio				0.5cc		SQ	
IPV					Polio				0.5cc		SQ	
PPV23					PPV				0.5cc		IM	
PPV23					PPV				0.5cc		IM	
Hepatitis A					Hep A						IM	
Hepatitis A					Hep A						IM	
HPV					HPV				0.5cc		IM	
HPV					HPV				0.5cc		IM	
HPV					HPV				0.5cc		IM	
Influenza					Flu				0.5cc		IM	
Influenza					Flu				0.5cc		IM	
Influenza					Flu				0.5cc		IM	
MCV4					Mening						IM	
MPSV4					Mening						SQ	

* 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: Maurice Brown Date of birth: 8/15/16
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Adults

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 weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, 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: [Signature] Date: 8/15/16
Form reviewed by: [Signature] Date: 8/15/16

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.