

AUM Student Health Services

Immunization Record

Patient Name:

Onyeka Ezekannagha

Birthdate:

9/1/89

Allergies/Medical Alert: NKA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B	11/9/2023	① deltoid 1m	LOT: 1337 EXP: 12/2024 NDC 58180-521-43 Hepatitis B Vaccine (Recombinant) ENGRIX-B 20 mcg/mL Mfr: GlaxoSmithKline Biologicals			10/19/21	ur
Other							

495702

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials

Initials	Signature	Initials	Signature
ur	ur [Signature]		

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 Onyeka Ezeannagha

DATE OF BIRTH 1 / 9 / 2023
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 Onyeka Ezeannagha DATE 1/9/2023

FORM REVIEWED BY NRN RN DATE 1/9/2023

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.



HEALTH EXAMINATION FORM

LAST NAME: Ezekannagha FIRST NAME: Onjeka TSCC ID #: A020103211 PHONE NUMBER: 334-202-8005

THE FOLLOWING INFORMATION MUST BE COMPLETED BY A PHYSICIAN, NURSE PRACTITIONER,

Allergies (Food/Drug/Latex, etc.) <u>None</u>								
C O M P L E T E	Height	<u>5' 8 inch</u>	Weight	<u>166</u>	BP	<u>124/84</u>	Pulse	<u>78</u>
	Vision Right 20/	<u>19</u>	Left 20/	<u>20</u>	Corrected:	<u>Y</u> ☐ <u>N</u> ☒		

The student has been diagnosed with a chronic/serious medical condition(s)? (Ex. Diabetes, hypertension, seizure disorders, etc.?) Yes ☒ No ☐

If yes, please list: _____

Is/are the condition(s) being presently controlled or treated? Yes ☐ No ☐ If yes, please describe: _____

The student has been diagnosed with a psychiatric/mental condition(s)? (Ex. Bipolar, depression, chemical dependency, etc.) Yes ☒ No ☐

Is/are the condition(s) being presently controlled or treated? Yes ☐ No ☐ If yes, please describe: _____

The student is taking prescribed medications on a regular basis? Yes ☒ No ☐

If yes, please list: _____

On the basis of my examination on this day 1.9.23, I approve the student's participation in Clinical Education.
month, day, year

Yes ☒ No ☐ Limited - If limited, please describe: _____

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Robin Blackwell, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell, CRNP

Provider:
Please place office stamp
here (if possible) for
validation purposes.

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HEPATITIS B IMMUNIZATION

LAST NAME: Oye Ezekannagha FIRST NAME: Onjeka TSCC ID #: A02103211

HAVE YOU COMPLETED A SERIES OF HEPATITIS B IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

HEPATITIS B IMMUNIZATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

STEP 1 - IF YOU HAVE COMPLETED A HEPATITIS B SERIES IN THE PAST - HAVE A TITER DRAWN AND COMPLETE THE FOLLOWING.
PLEASE NOTE THAT IF YOUR TITER IS NEGATIVE YOU MUST COMPLETE STEP 2.

DATE OF TITER: _____ POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? _____ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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NOT due until
2/9/2023.

IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!
IF YOUR RESULTS ARE NEGATIVE - COMPLETE STEP 2 BELOW.

STEP 2 - IF YOU HAVE NOT COMPLETED A HEPATITIS B IMMUNIZATION OR IF YOU HAD A NEGATIVE TITER - A FULL 3-PART SERIES IMMUNIZATION IS REQUIRED.

1ST VACCINATION DATE: 2/3/2022

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____
AUBURN UNIVERSITY MONTGOMERY

Provider: STUDENT HEALTH CENTER
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validation purposes. IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
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2ND VACCINATION DATE: 3/3/2022
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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3RD VACCINATION DATE: 1/9/2023
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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Provider:
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validation purposes.

titer due 2/9/2023

AFTER COMPLETION OF 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B SURFACE ANTIGENS (anti-HBs) TO DOCUMENT IMMUNITY:

DATE OF TITER: _____ POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? _____ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a ✓)

Patient Information	Specimen Information	Client Information
EZEKANNAGHA, ONYEKA DOB: 09/01/1989 AGE: 33 Gender: F Phone: NG Patient ID: 5024	Specimen: AL804593Y Requisition: 2920247 Lab Ref #: 00855528 Collected: 01/09/2023 / 16:48 CST Received: 01/10/2023 / 03:16 CST Reported: 01/10/2023 / 06:03 CST	Client #: 49100638 QATL0000 BLACKWELL, ROBIN AUM NURSING CARE CENTER 7461 EAST DRIVE #102 MONTGOMERY, AL 36117

PROVIDER: BICKNEIJ. MIRANDA

Test Name	In Range	Out Of Range	Reference Range	Lab
CBC (INCLUDES DIFF/PLT)				AT
WHITE BLOOD CELL COUNT	5.8		3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	4.14		3.80-5.10 Million/uL	
HEMOGLOBIN		11.0 L	11.7-15.5 g/dL	
HEMATOCRIT		34.1 L	35.0-45.0 %	
MCV	82.4		80.0-100.0 fL	
MCH		26.6 L	27.0-33.0 pg	
MCHC	32.3		32.0-36.0 g/dL	
RDW	12.4		11.0-15.0 %	
PLATELET COUNT	335		140-400 Thousand/uL	
MPV	11.2		7.5-12.5 fL	
ABSOLUTE NEUTROPHILS	2732		1500-7800 cells/uL	
ABSOLUTE LYMPHOCYTES	2355		850-3900 cells/uL	
ABSOLUTE MONOCYTES	609		200-950 cells/uL	
ABSOLUTE EOSINOPHILS	52		15-500 cells/uL	
ABSOLUTE BASOPHILS	52		0-200 cells/uL	
NEUTROPHILS	47.1		%	
LYMPHOCYTES	40.6		%	
MONOCYTES	10.5		%	
EOSINOPHILS	0.9		%	
BASOPHILS	0.9		%	

PERFORMING SITE:

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

LIST OF RESULTS PRINTED IN THE OUT OF RANGE COLUMN:

HEMOGLOBIN	11.0 L	11.7-15.5 g/dL	AT
HEMATOCRIT	34.1 L	35.0-45.0 %	AT
MCH	26.6 L	27.0-33.0 pg	AT

ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: EZEKANNAGHA, ONYEKA D
 DOB: 09/01/1989
 Chart #: _____
 Date of Service: 01/10/2023

Vaccine Family	Type of Vaccine (no Brand Name)	Date Given (mm/dd/yy)	Age at Adm	Dose (cc/mL)	Route & Site	Mfr.	Lot #	VIS Date	Vaccinator Signature
Tetanus, Diptheria, (Pertussis) (e.g., Td, Tdap)	TDAP	01/06/22	32 y	0.5	IM LD	SKB	M442P		
Hepatitis A (e.g., HepA, HepA-HepB)									
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADULT	02/03/22	32 y	1.0	IM	SKB	XA4DD		OUTSIDE CLINIC
	HEP B ADULT	03/03/22	32 y	1.0	IM	SKB	4F472		OUTSIDE CLINIC
	HEP B ADULT	01/09/23	33 y	1.0	IM LD	SKB	NT9X3		
Human Papillomavirus (e.g., HPV)									
Measles, Mumps, Rubella (MMR, MMRV)	MMR	02/03/22	32 y	0.5	SC	MSD			OUTSIDE CLINIC
	MMR	03/03/22	32 y	0.5	SC	MSD			OUTSIDE CLINIC
Meningococcal (MCV4, MPSV4)									
Pneumococcal (e.g. PCV, PPV)									
Polio (e.g., IPV, DTaP-HepB-Hib)									
Varicella (Var, MMRV)									
Influenza (e.g., TIV, LAIV)									
Zoster									
Other	Pfizer Covid19 (NonDiluent)	05/13/22	32 y	0.3	IM LD	PFR	FP4554		OUTSIDE CLINIC

WARHAWK HEALTH SERVICES
 7461 EAST DRIVE
 RM 102 MOORE HALL
 MONTGOMERY, AL36117
 334 2443281

PPD	Date	Results	PPD	Date	Results
Mantoux			Mantoux		
Mantoux			Mantoux		
Mantoux			Mantoux		