

**AUM Student Health Services
Immunization Record**

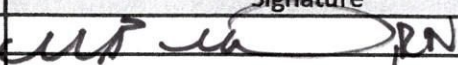
Patient Name: Jordan Fain

Birthdate: 8/17/99

Allergies/Medical Alert: N/A

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap	7/2/2015	(R) deltoid 1m		LOT: KR75K EXP: 08/27/27		1131/25	JNF
Td Booster				NDC 58160-842-43 Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX 0.5 mL Mfd. by GlaxoSmithKline Biologicals			
MMR							
HEP A							
HEP B	7/2/2015	(L) deltoid 1m		LOT: T5D73 EXP: 04/10/27		1131/2015	JNF
Other				NDC 58160-821-43 Hepatitis B Vaccine (Recombinant) ENGRIX-B 20 mcg/mL Mfd. by GlaxoSmithKline Biologicals			

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

Initials	Signature	Initials	Signature
JNF			

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

YOUR NAME Jordan Fam
DATE OF BIRTH 08 / 17 / 1985
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 we need to ask you more questions. 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 vaccine?	☐	☒	☐
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☒	☐
7. In the past 6 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?	☐	☒	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☒	☐
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☒	☐
11. Are you pregnant?	☐	☒	☐
12. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐
13. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☒	☐
14. Are you anxious about getting a shot today?	☐	☒	☐

FORM COMPLETED BY [Signature] DATE 7/12/25

FORM REVIEWED BY [Signature] DATE 7/14/25

Did you bring your immunization record card with you? yes ☐ no ☐

It is important 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.



FOR PROFESSIONALS www.immunize.org / FOR THE PUBLIC www.vaccineinformation.org

www.immunize.org/catg.d/p4065.pdf

Item #P4065 (11/6/2023)

