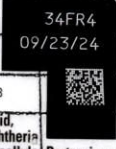


AUM Student Health Services  
Immunization Record

Patient Name: Sai Lakshmi Sundeep

Birthdate: 4/22/1998

Allergies/Medical Alert: NKA

| Immunization | Date              | Site                | Dose                                                                                                                                                            | MFR    | Comments | V.I. S.        | Initials  |
|--------------|-------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|----------|----------------|-----------|
| <u>Tdap</u>  | <u>11/11/2022</u> | <u>Left Deltoid</u> | LOT: 34FR4<br>EXP: 09/23/24<br>                                                |        |          | <u>9/10/21</u> | <u>WS</u> |
|              |                   | <u>Im</u>           | NDC 58180-842-43<br>Tetanus Toxoid, Reduced Diphtheria Toxin and Acellular Pertussis Vaccine, Adsorbed<br><b>BOOSTRIX</b><br>Mfd by GlaxoSmithKline Biologicals | 0.5 mL |          |                |           |
| Td Booster   |                   |                     |                                                                                                                                                                 |        |          |                |           |
| MMR          |                   |                     |                                                                                                                                                                 |        |          |                |           |
| HEP A        |                   |                     |                                                                                                                                                                 |        |          |                |           |
| HEP B        |                   |                     |                                                                                                                                                                 |        |          |                |           |
| Other        |                   |                     |                                                                                                                                                                 |        |          |                |           |

|                                                  | Date Given:       | Date Read:        | Results:   | MFR           | LOT#           | Comments            | Initials        |
|--------------------------------------------------|-------------------|-------------------|------------|---------------|----------------|---------------------|-----------------|
| Tuberculin Testing<br>PPD (MANTOUX)<br>0.1 ml ID | <u>11/11/2022</u> | <u>11/14/2022</u> | <u>8mm</u> | <u>Sanofi</u> | <u>C5805AA</u> | <u>exp. 3/17/23</u> | <u>(C)FA WS</u> |
|                                                  |                   |                   |            |               |                |                     |                 |
|                                                  |                   |                   |            |               |                |                     |                 |
|                                                  |                   |                   |            |               |                |                     |                 |

| Initials  | Signature        | Initials | Signature |
|-----------|------------------|----------|-----------|
| <u>WS</u> | <u>WS M. JEN</u> |          |           |
|           |                  |          |           |
|           |                  |          |           |

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

# Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME

Sai Sundeeep

DATE OF BIRTH

04/22/98  
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?                                                                                                                                                                                                                                             | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have allergies to medications, food, a vaccine component, or latex?                                                                                                                                                                                      | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction after receiving a vaccination?                                                                                                                                                                                             | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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?                                                                                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?                                                                                                                                                                                     | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a seizure or a brain or other nervous system problem?                                                                                                                                                                                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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?                                                                                                                   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?                                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 10. Have you received any vaccinations in the past 4 weeks?                                                                                                                                                                                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

FORM COMPLETED BY Ch. Sundeeep

DATE 11/11/22

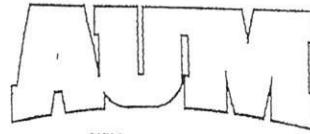
FORM REVIEWED BY NR RN

DATE 11/11/2022

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.



**WARHAWK  
HEALTH SERVICES**

**TB Screening Questionnaire**

Name: SAT LAKSHMI NARAYANA SANDEEP <sup>CHUNDURU</sup> Date of Birth: 04/22/1998

Student Number: 500423308

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

YES NO

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

**\*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: Ch. Sandeep

Date: 11/11/22

Provider Signature: UB

Date: 11/11/2022