



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Zeigler

FIRST NAME: Kazaha

TSCC ID #: _____

TUBERCULIN (TB) 2 STEP MANTOUX SKIN TEST - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

STEP 1 - TEST #1:

NAME OF PERSON ADMINISTERING: Miranda Bicknell RN

DATE ADMINISTERED (TEST #1): 12/2/22 LOT #: C5800AA

EXPIRATION DATE: 3/29/23

DATE READ: 12/5/22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 1 RESULTS: ☐ POSITIVE ☒ NEGATIVE ☐ REDNESS (please identify results with a ✓)

0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

On the date read (48-72 hrs after it is administered), your provider will evaluate, measure, and interpret the area. Your provider will document the millimeters (e.g. 0 mm, 4 mm, 12 mm) and if the 1st TST is negative, you will return for the 2nd test in 7-21 days. If the 1st test is positive, you should see your provider for additional evaluation and treatment.

IF TEST #1 WAS NEGATIVE - WAIT 7-21 DAYS BEFORE COMPLETING STEP 2

STEP 2 - TEST #2 - 7 - 21 DAYS AFTER STEP 1

NAME OF PERSON ADMINISTERING: Miranda Bicknell RN

DATE ADMINISTERED (TEST #2): 12/12/22 LOT #: C5800AA

EXPIRATION DATE: 3/29/23

DATE READ: 12/14/22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 2 RESULTS: ☐ POSITIVE ☒ NEGATIVE ☐ REDNESS (please identify results with a ✓)

0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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

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

On the date read (48-72 hrs after TEST #2), your provider will evaluate, measure, and interpret the TST. Document the millimeters (e.g. 0 mm, 4 mm, 12 mm).
If the 2nd TST is negative - you are done!

On the date read (48-72 hrs after TEST #2), your provider will evaluate, measure, and interpret the TST. Document the millimeters (e.g. 0 mm, 4 mm, 12 mm).
If the 2nd TST is positive, you should see your provider for additional information & treatment.

IMPORTANT NOTE:

If a TB skin test cannot be performed due to past + test or BCG vaccination:

1) Your provider will likely order a chest x-ray and you will provide the program with a Radiologist's report - OR

2) Your provider (or provider letterhead) can document that you are free from TB and do not need a 2-step TB test or chest x-ray

**AUM Student Health Services
Immunization Record**

Patient Name: Kazuhisa Zeigler

Birthdate: 10/30/1998

Allergies/Medical Alert: NKA - dairy causes hives

Immunization	Date	Site	Dose	MFR	Comments	V.I.S.	Initials
Tdap	12/2/22	② deltoid 1m	LOT: [redacted] EXP: [redacted] NDC 58160-942-43	[redacted]		8/6/21	WBS
Td Booster			Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX	0.5 ml			
MMR			Mfg. by GlaxoSmithKline Biologicals	1.0 ml			
HEP A							
HEP B	12-7-22	④ deltoid	LOT: 25K3M EXP: 05/02/24 NDC 38160-921-43 Hepatitis B Vaccine (Recombinant) ENGRIX-B	[redacted]		10/15/21	DM
Other			Mfg. by GlaxoSmithKline Biologicals	1.0 ml			

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	12/2/22	12/5/22	0mm	Sanofi	C5800AA	exp 3/25/23 (C)FA	WBS
	12/17/22	12/14/22	0mm	Sanofi	C5800AA	exp 3/25/23 (C)FA	WBS

Initials	Signature	Initials	Signature
WBS	WBS [signature]		

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STAMP ABOVE



HEPATITIS B IMMUNIZATION

LAST NAME: Zeigler

FIRST NAME: Kazuh

TSSC ID #: _____

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: 12/2/22 POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? X (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Lindsey Barton, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

[Signature]

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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: 12/2/2022

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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validation purposes.

2ND VACCINATION DATE _____
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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validation purposes.

3RD VACCINATION DATE _____
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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validation purposes.

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 $\checkmark$)



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Zeigler

FIRST NAME: Korah

TSCC ID #: _____

MEASLES/MUMPS/RUBELLA (MMR) IMMUNIZATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

HAVE YOU RECEIVED YOUR MMR IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

STEP 1 - IF YOU HAVE COMPLETED AN MMR IMMUNIZATION IN THE PAST - HAVE A TITER DRAWN - AND HAVE YOUR PROVIDER COMPLETE THE FOLLOWING. IF ANY RESULTS ARE NEGATIVE - SEE STEP 2 - RE-IMMUNIZATION IS REQUIRED.

DOSE #1

DATE OF MEASLES (RUBEOLA) TITER: 12/2/22 **POSITIVE?** (≥ 1.1 AI) **NEGATIVE?** (≤ 0.8 AI) (please identify results with a ✓) **POSITIVE?**

DATE OF MUMPS TITER: 12/2/22 (≥ 1.1 AI) **NEGATIVE?** (≤ 0.8 AI) (please identify results with a ✓) **POSITIVE?** (≥ 1.1

DATE OF RUBELLA (MEASLES) TITER: 12/2/22 AI) **NEGATIVE?** (≤ 0.7 AI) (please identify results with a ✓)

positive titer for mmr

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Lindsey Barton, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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

MEASLES, MUMPS, RUBELLA (MMR) VACCINATION

STEP 2 - IF YOU HAVE NOT HAD AN MMR IMMUNIZATION OR IF YOU HAVE A NEGATIVE TITER - IMMUNIZATION IS REQUIRED.

DOSE # 1	MEASLES (RUBEOLA)	DATE: _____	DOSE # 2	MEASLES (RUBEOLA)	DATE: _____
DOSE # 1	MUMPS	DATE: _____	DOSE # 2	MUMPS	DATE: _____
DOSE # 1	RUBELLA (MEASLES)	DATE: _____	DOSE # 2	RUBELLA (MEASLES)	DATE: _____

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Zeigler

FIRST NAME: Kazuh

TSCC ID #: _____

VARICELLA/CHICKEN POX IMMUNIZATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

HAVE YOU RECEIVED YOUR VARICELLA/CHICKEN POX IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

STEP 1 - IF YOU HAVE PREVIOUSLY COMPLETED A VARICELLA/CHICKEN POX IMMUNIZATION OR HAVE HAD THE CHICKEN POX - HAVE A TITER DRAWN AND HAVE YOUR PROVIDER COMPLETE THE FOLLOWING. IF RESULTS ARE NEGATIVE - SEE STEP 2 - RE-IMMUNIZATION IS REQUIRED.

DATE OF VARICELLA TITER: 12/1/02 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Lindsey Barton, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

[Signature]

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IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!

IF YOUR RESULTS ARE NEGATIVE - COMPLETE STEP 2 BELOW.

STEP 2 - IF YOU HAVE NOT HAD A VARICELLA/CHICKEN POX VACCINATION OR A NEGATIVE TITER RESULT - VARICELLA IMMUNIZATION IS REQUIRED.

VARICELLA/CHICKEN POX VACCINE

DATE OF VARICELLA VACCINE #1: _____

DATE OF VARICELLA VACCINE #2: _____

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Zeigler

FIRST NAME: Korana

TSCC ID #: _____

TETANUS, DIPHTHERIA, & PERTUSSIS (TDAP) VACCINATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

A TDAP BOOSTER IS REQUIRED EVERY 10 YEARS AFTER INITIAL VACCINE.

DATE OF ORIGINAL TDAP VACCINATION: 11/1/99
DTap.

DATE OF MOST RECENT BOOSTER: 12/2/02

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Lindsey Burton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

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Trenholm State
COMMUNITY COLLEGE

Alabama Community College System
Nursing Programs Essential Functions Form
Acknowledgment Page

Note to all applicants: The essential functions form must be signed and dated by the student. This states that you have read and agreed to the terms. You will receive the essential functions form for the nursing program once accepted into the program for a healthcare provider to complete.

Kazana Zeigler
Print Applicant's Name

Kazana Zeigler
Applicant's Signature

J. H. Hinton
Physician's Signature

A02413000
Applicant's A#

12/02/2022
Date

12/12/2022
Date

I Kazana Zeigler have revealed my medical history truthfully and completely.
(Print Applicant's Name)

I authorize my medical provider to give information to the Trenholm State Community College Nursing Department regarding my ability to participate in clinical rotations.

Kazana Zeigler
Applicant's Signature and Date



INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Zeigler FIRST NAME: Kazuha TSCC ID #: _____

SEASONAL INFLUENZA (FLU SHOT) VACCINATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE

FLU SEASON TYPICALLY BEGINS MID-SEPTEMBER
VACCINATIONS ARE NOT AVAILABLE BEFORE THIS TIME

DATE ADMINISTERED: 12/2/22 MANUFACTURER: GSK LOT #: m3R5B EXPIRATION DATE: 03/01/23

SITE OF INJECTION: ☒ LEFT DELTOID ☐ RIGHT DELTOID (please identify location of injection with a ✓)

PROVIDER - PLEASE PRINT THE FOLLOWING INFORMATION:

NAME OF PERSON ADMINISTERING: Miranda Rickert CREDENTIALS OF PERSON ADMINISTERING: RN

SIGNATURE OF PERSON ADMINISTERING: [Signature]

NAME OF OFFICE OR FACILITY: Auburn University Montgomery PHONE #: (334) 244-3281

STREET ADDRESS: 7401 East DL CITY: Montgomery STATE: AL ZIP CODE: 36117

Provider:
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here (if possible) for
validation purposes.

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ADULT IMMUNIZATION RECORD

Allergies: _____

Reactions: _____

Name: ZEIGLER, KAZAHA MONICE
 DOB: 10/30/1998
 Chart #: _____
 Date of Service: 12/01/2022

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, Diphtheria, (Pertussis) (e.g., Td, Tdap)	DTAP	01/11/99	2 m	0.5					
	DTAP	03/19/99	4 m	0.5					
	DTAP	06/07/99	7 m	0.5					
	DTAP	11/15/02	4 y	0.5					
Hepatitis A (e.g., HepA, HepA-HepB)	HEP A	09/06/11	12 y	1.0		MSD			OUTSIDE CLINIC
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PED	10/30/98	0 m	0.5					OUTSIDE CLINIC
	HEP B ADOL/PED	12/10/98	1 m	0.5					
Human Papillomavirus (e.g., HPV)	HPV (GARDASIL)	09/06/11	12 y	1.0		MSD			OUTSIDE CLINIC
	HPV (GARDASIL)	02/01/13	14 y	0.5		MSD			OUTSIDE CLINIC
Measles, Mumps, Rubella (MMR, MMRV)	MMR	08/06/04	5 y	0.5					
Meningococcal (MCV4, MPSV4)									
Pneumococcal (e.g. PCV, PPV)	PPV23	03/01/01	2 y	0.5					
Polio (e.g., IPV, DTaP-HepB-Hib)	IPV	01/11/99	2 m	0.5					
	IPV	03/19/99	4 m	0.5					
	OPV	06/07/99	7 m	0.5					
	IPV	11/15/02	4 y	0.5					
Varicella (Var, MMRV)									
Influenza (e.g., TIV, LAIV)	INFLUENZA SPLIT PSA	09/06/11	12 y	1.0		PMC			OUTSIDE CLINIC
	IIIV4 MDCK P-FREE	08/22/17	18 y	0.5		SEQ			
	IIIV4 - P FREE	09/09/18	19 y	0.5		SEQ			
Zoster									
Other	HIB UNS	01/11/99	2 m						
	HIB UNS	03/19/99	4 m						

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		



HEALTH EXAMINATION FORM

LAST NAME: Zeigler FIRST NAME: Kazaba TSCC ID #: _____ PHONE NUMBER: _____

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

Allergies (Food/Drug/Latex, etc.) <u>NKDA</u>			
C O M P L E T E	Height <u>68 in.</u>	Weight <u>258.2</u>	BP <u>132/83</u>
	Pulse <u>93</u>		
	Vision Right 20/ <u>25</u>	Left 20/ <u>20</u>	Corrected: Y ☐ N ☐
		NORMAL	ABNORMAL FINDINGS
	CBC	✓	
	Cardiovascular	✓	
	Pulses	✓	
	Heart	✓	
	Lungs	✓	
	Skin	✓	
	E.N.T.	✓	
	Gastrointestinal	✓	
	Musculoskeletal	✓	
	Neurological	✓	
	Other		

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

If yes, please list: Eczema

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: Dupixent injections

On the basis of my examination on this day 12/2/22, 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) Lindsey Barton, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

[Signature]

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MONTGOMERY, AL 36124-4023



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Kazana Zeigler DOB: 10/30/1998 Phone: 251 58 0041
Mailing Address: 12135 S Hampton City: Montgomery ST: AL Zip: 361
Insurance Company: BCBS Subscriber name: JOSEPH ZEIGLER DOB: 01/18/1981
Insurance Contract Number: E1B901337590 Group number: 13000

Screening Questions:	Yes	No	Don't Know
1) Are you sick today? (cold, fever, acute illness)	☐	☒	☐
2) Do you have allergies to any foods, medications or latex? (For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations) List: <u>Dairy (cashed, HIVES)</u>	☒	☐	☐
3) Have you had any serious reactions from a vaccine? <u>Flu (cashed/HIVES)</u>	☐	☒	☐
4) Have you been diagnosed with Guillain-Barre syndrome?	☐	☒	☐

CHICKS
ECZEMA
Flare up.

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request,

Signature: Kazana Zeigler Date: 12/02/2022
Administration Date: 12/2/2022 Route: IM LD or RD Volume: 0.5ml
Administrator: M. Bicknell, RN VIS Date 08/15/2019
Manufacturer: GSK Fluarix® Quadrivalent Lot # M3R5B Expires 06/30/2023
Temp: 96.7

LOT: M3R5
EXP: 06/30/23
NDC 58160-930-41
Influenza Vaccine
FLUARIX QUADRIVALENT
2022/2023 Formula
0.5 mL
Mfg. by
GlaxoSmithKline
Bioscience



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Kazana Zeigler

Date of Birth: 10/30/1998

Student Number: A02413806

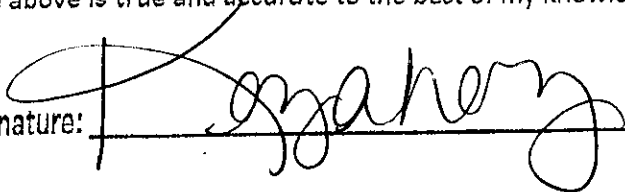
Please mark "yes" or "no" to the following questions.

YES NO

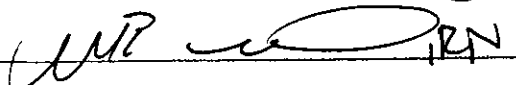
1. Do you have a cough that has lasted longer than 3 weeks?		X
2. Have you coughed up blood or mucus?		X
3. Have you had fever, chills, or night sweats?		X
4. Have you had unintentional weight loss?		X
5. Have you been feeling very tired?		X
6. Have you lost your appetite?		X
7. Have you ever had a positive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

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: 

Date: 12/02/2022

Provider Signature: 

Date: 12/2/2022

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Kazaha Zeigler

DATE OF BIRTH 11 / 30 / 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?	☐	☒	☐
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? <u>anemia flare up after flu shot (Flu)</u>	☐	☒	☐
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? <u>anemia pregnant</u>	☐	☐	☒
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? <u>dupixent</u>	☒	☐	☐
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? <u>injection dupixent</u>	☐	☒	☐

FORM COMPLETED BY Kazaha Zeigler DATE 12/02/2022

FORM REVIEWED BY [Signature] DATE 12/2/2022
Tdap: 12/2/22

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.