

**AUM Student Health Services
Immunization Record**

Patient Name: Amber Turner

Birthdate: 12/29/96

Allergies/Medical Alert: NKA

Immunization	Date	Site	Dose	MFR	Comments	V.I.S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B	11/8/2023	One Hit				10/15/21	MS
Varicella	11/8/2023	2 T arm				8/16/21	MS
Other		Sub Q					

LOT: 01224
EXP: 03/2024
NDC 58160-921-43
Hepatitis B Vaccine (Recombinant) ENGERIX-B
20 mcg/mL
485702
1 Single-dose 0.5-mL Vial
VARICELLA VIRUS VACCINE LIVE VARIVAX®
STORE FROZEN: -58°F TO +5°F
Manufactured by: Merck Sharp & Dohme Corp., a subsidiary of
MERCK & CO., INC.
Whitehouse Station, NJ 08889, USA
Lot & Exp: W018829
2024 JUN 14

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing: PPD (MANTOUX) 0.1 ml ID	11/9/2023	1/11/23	0mm	Sanofi	05807AA	exp 9/19/23 UFA	MS
	11/8/2023	1/20/23	0mm	Sanofi	05806AA	exp 3/25/23 UFA	MS

Initials	Signature	Initials	Signature
MS	MS [Signature]		

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

STAMP ABOVE



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Turner

FIRST NAME: Amber

TSCC ID #: A02120712

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): 11/9/23 LOT #: CS807AA

EXPIRATION DATE: 4/19/2023

DATE READ: 11/11/23 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 1 RESULTS: 0 POSITIVE X NEGATIVE 0 REDNESS (please identify results with a ✓)

0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: Rick Blackwell CRNP

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): 11/9/2023 LOT #: CS807AA

EXPIRATION DATE: 3

DATE READ: 11/20/23 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 2 RESULTS: 0 POSITIVE X NEGATIVE 0 REDNESS (please identify results with a ✓)

0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: Rick Blackwell CRNP

AUBURN UNIV Provider: MONTGOMERY
STATION
Please place office stamp
IRMA here (if possible) for
validation purposes.
MONTGOMERY 11/20/23

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:



HEPATITIS B IMMUNIZATION

LAST NAME: Turner

FIRST NAME: Amber

TSCC ID #: A02120712

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: 11/9/2023 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) Robin Blackwell, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CRNP

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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: 11/18/2023

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: Robin Blackwell CRNP

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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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 $\checkmark$)



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Turner

FIRST NAME: Amber

TSCC ID #: A02120712

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: 1/19/23 POSITIVE? (≥ 1.1 AI) NEGATIVE? X (≤ 0.8 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CRNP

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MONTGOMERY, AL 36124-4023

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: 1/18/23

DATE OF VARICELLA VACCINE #2:

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CRNP

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due for varicella
titer 1 month
from 1/19/23

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Amber Turner

DATE OF BIRTH 12 / 29 / 96
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 Amber Turner DATE 11/18/23

FORM REVIEWED BY Debra Manzotti DATE 11/18/23

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: Amber Turner

Date of Birth: 12/29/96

Student Number: Trenholm Student

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

YES NO

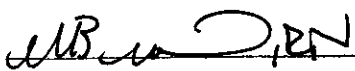
1. Do you have a cough that has lasted longer than 3 weeks?		✓
2. Have you coughed up blood or mucus?		✓
3. Have you had fever, chills, or night sweats?		✓
4. Have you had unintentional weight loss?		✓
5. Have you been feeling very tired?		✓
6. Have you lost your appetite?		✓
7. Have you ever had a positive TB skin test result or Positive interferon gamma release assay (IGRA) result? 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: 

Date: 11/9/23

Provider Signature: 

Date: 11/9/23



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Turner

FIRST NAME: Amber

TSCC ID #: 102120712

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: 11/9/23

POSITIVE? (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE? ✓

DATE OF MUMPS TITER: 11/9/23

(≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE? ✓ (≥ 1.1 AI)

DATE OF RUBELLA (MEASLES) TITER: 11/9/23

AI) NEGATIVE? (≤ 0.7 AI) (please identify results with a ✓)

MMR Titer positive for immunity

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell, CRNP AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER

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MONTGOMERY, AL 36124-4023

Provider:
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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 _____

Provider:
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HEALTH EXAMINATION FORM

LAST NAME: Turner FIRST NAME: Amber TSCC ID #: A02127013 PHONE NUMBER: 251-458-7760

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

Allergies (Food/Drug/Latex, etc.) <u>None.</u>				
C O M P L E T E	Height <u>67</u>	Weight <u>348.6</u>	BP <u>102</u>	
	Pulse <u>136/84</u>			
	Vision Right 20/ <u>20</u>	Left 20/ <u>20</u>	Corrected: ☒ YES ☐ NO	
		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: _____

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: Bipolar

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

If yes, please list: Scroquel 50mg Lexapro 10 mg

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 CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CNP

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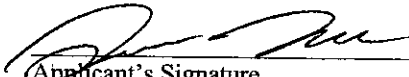
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Note to all applicants: The essential functions form must be signed and dated by the student. This states that you have read and agreed to the terms. You will receive the essential functions form for the nursing program once accepted into the program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

Amber Turner
Print Applicant's Name

A02120712
Applicant's A#


Applicant's Signature

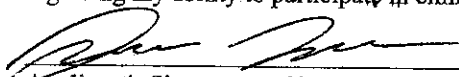
11/9/23
Date

Robin Blackwell CRNP
Physician's Signature

1.10.23
Date

I Amber Turner 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.


Applicant's Signature and Date



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.

Amber Turner
Print Applicant's Name

A02127012
Applicant's A#

[Signature]
Applicant's Signature

1/4/23
Date

Rosi Badweu
Physician's Signature

1.9.23
Date

I Amber Turner 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.

[Signature]
Applicant's Signature and Date



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Turner

FIRST NAME: Amber

TSCC ID #: A02120112

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: 2/12/1999

DATE OF MOST RECENT BOOSTER: 5/15/2017

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) per vaccine record
PT on 3/11/1997
Robin Blackwell, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell, CRNP

Provider:
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MONTGOMERY, AL 36124-4023

Patient Information	Specimen Information	Client Information
TURNER, AMBER DOB: 12/29/1996 AGE: 26 Gender: F Phone: 251.458.7761 Patient ID: 5260	Specimen: AL804594Y Requisition: 2920259 Lab Ref #: 00855530 Collected: 01/09/2023 / 16:48 CST Received: 01/10/2023 / 03:17 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: BICKNELL MIRANDA

Test Name	In Range	Out Of Range	Reference Range	Lab
CBC (INCLUDES DIFF/PLT)				AT
WHITE BLOOD CELL COUNT	8.2		3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	4.33		3.80-5.10 Million/uL	
HEMOGLOBIN	12.1		11.7-15.5 g/dL	
HEMATOCRIT	36.9		35.0-45.0 %	
MCV	85.2		80.0-100.0 fL	
MCH	27.9		27.0-33.0 pg	
MCHC	32.8		32.0-36.0 g/dL	
RDW	12.1		11.0-15.0 %	
PLATELET COUNT	399		140-400 Thousand/uL	
MPV	10.1		7.5-12.5 fL	
ABSOLUTE NEUTROPHILS	4846		1500-7800 cells/uL	
ABSOLUTE LYMPHOCYTES	2665		850-3900 cells/uL	
ABSOLUTE MONOCYTES	615		200-950 cells/uL	
ABSOLUTE EOSINOPHILS	41		15-500 cells/uL	
ABSOLUTE BASOPHILS	33		0-200 cells/uL	
NEUTROPHILS	59.1		%	
LYMPHOCYTES	32.5		%	
MONOCYTES	7.5		%	
EOSINOPHILS	0.5		%	
BASOPHILS	0.4		%	

PERFORMING SITE:

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

ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: TURNER, AMBER KENNEDRA
 DOB: 12/29/1996
 Chart #: _____
 Date of Service: 12/07/2022

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	03/16/97	2 m	0.5					
	DTP-HIB	05/06/97	4 m	0.5					
	DTAP	01/14/98	12 m	0.5					
	DTAP	03/07/01	4 y	0.5					OUTSIDE CLINIC
	TDAP	02/12/09	12 y	0.5					
	TDAP	05/15/17	20 y	0.5	IM	PMC	X994C		OUTSIDE CLINIC
Hepatitis A (e.g., HepA, HepA-HepB)									
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PED	12/29/96	0 m	0.5					
	HEP B UNS	03/07/97	2 m	0.5					
	HEP B UNS	06/16/97	5 m	0.5					
Human Papillomavirus (e.g., HPV)	HPV (GARDASIL)	09/26/06	9 y	0.5					
	HPV (GARDASIL)	05/11/07	10 y	0.5					
Measles, Mumps, Rubella (MMR, MMRV)	MMR	01/14/98	12 m	0.5					
	MMR	03/07/01	4 y	0.5	RA	MSD	1505J		OUTSIDE CLINIC
Meningococcal (MCV4, MPSV4)	MCV4P (MENACTRA)	02/12/09	12 y	0.5					
Pneumococcal (e.g. PCV, PPV)	PCV7	03/07/01	4 y	0.5	RD				OUTSIDE CLINIC
Polio (e.g., IPV, DTaP-HepB-Hib)	OPV	03/07/97	2 m	0.5	PO				
	OPV	05/06/97	4 m	0.5	PO				
	OPV	06/16/97	5 m	0.5					
	IPV	03/07/01	4 y	0.5	LA				OUTSIDE CLINIC
Varicella (Var, MMRV)	VARICELLA	01/14/98	12 m	0.5					
Influenza (e.g., TIV, LAIV)									
Zoster									
Other	HIB UNS	06/16/97	5 m						
	HIB UNS	01/14/98	12 m						
	Pfizer Covid19	08/30/21	24 y		IM	PFR	FC3180		OUTSIDE CLINIC
	Pfizer Covid19	09/20/21	24 y		IM	PFR	FF2588		OUTSIDE CLINIC

AFC PRIMED ATLANTA HIGHWAY
4305 ATLANTA HWY

MONTGOMERY, AL36109
334 3232260

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

Alabama Department of Public Health

CERTIFICATE OF IMMUNIZATION

12/29/2018

Date of Expiration

(Next Required Immunization)

AMBER KENNEDRA TURNER

12/29/1996

Child's Name (first, middle, last)

Birthdate

LOUISE TURNER

Parent/Guardian Name (first, middle, last)

Unless Specifically exempted by law, Alabama law (code of Alabama 1975, Section 16-30-4) requires a certificate on file for each child in attendance in all schools and licensed child care facilities in Alabama. Instructions for this form and immunization requirements by age are detailed via the ADPH web site at www.adph.org/immunization

Vaccine	DOSE1 DATE MM DD YY	DOSE2 DATE MM DD YY	DOSE3 DATE MM DD YY	DOSE4 DATE MM DD YY	DOSE5 DATE MM DD YY	DOSE6 DATE MM DD YY	Total Doses	Confirmed Lab MM YY	History MM YY
Recommended Vaccines for School or Child Care Attendance									
DTP, DTaP, DT, Td, Tdap	DTaP 03/16/97	DTaP-HIB 05/06/97	DTaP 01/14/98	DTaP 03/07/01	TDaP 02/12/09				
IPV, OPV	OPV 03/07/97	OPV 05/06/97	OPV 06/16/97	IPV 03/07/01					
Hib (Under Age 5)	DTaP-HIB 05/06/97	HIB 05/06/97	HIB 01/14/98						
Measles	MMR 01/14/98	MMR 03/07/01							
Mumps	MMR 01/14/98	MMR 03/07/01							
Rubella	MMR 01/14/98	MMR 03/07/01							
PCV	PCV7 03/07/01								
Varicella	VAR 01/14/98								

Recommended Vaccines									
HepA									
HepB	HEP B 07/25/99	HEP B 03/07/97	HEP B 06/16/97						
HPV	HPV (GARDASIL) 06/25/06	HPV (GARDASIL) 05/11/07							
MCV or MPSV	MenACWY (MCV4) 02/12/09								
Rotavirus									

NOTES

A licensed physician or qualified employee of the Alabama Dept. of Public Health is responsible for the content of this certificate. All dates must include in the month, day, and year. In cases of history of disease or laboratory confirmation, the 4 digit year of infection, or test must be filled in the appropriate boxes.

The certificate is NOT valid without the name and birth date of the child, date of expiration, legible name and address of the physician or health department, certified by signature, and the date of issue. A school or facility official is responsible for keeping a current valid Certificate on the file for each child in attendance. When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian.

Clinic Name: FPHC - AIELLO BUSKEY
MEDICALAddress: 424 SOUTH WILSON AVE
PRICHARD 36610

Telephone #: (251) 452-4442

Certified by (Signature)

6/28/2012

Date of Issue

AMBER KENNEDRA TURNER

Child's Name (first, middle, last)

12/29/1996

Birthdate

Date of Expiration

(Next Required Immunization)

LOUISE TURNER

Parent/Guardian Name (first, middle, last)

Unless Specifically exempted by law, Alabama law (code of Alabama 1975, Section 16-30-4) requires a certificate on file for each child in attendance in all schools and licensed child care facilities in Alabama. Instructions for this form and immunization requirements by age are detailed via the ADPH web site at www.adph.org/immunization

Vaccine	DOSE1 DATE MM DD YY	DOSE2 DATE MM DD YY	DOSE3 DATE MM DD YY	DOSE4 DATE MM DD YY	DOSE5 DATE MM DD YY	DOSE6 DATE MM DD YY	Total Doses	Confirmed Lab MM YY	History MM YY
Required Vaccines for School or Child Care Attendance									
DTP,DTaP,DT, Td,Tdap	DTAP 03/16/97	DTP-HIB 05/06/97	DTAP 01/14/98	DTAP 03/07/01	TDAP 02/12/09				
IPV,OPV	OPV 03/07/97	OPV 05/06/97	OPV 06/16/97	IPV 03/07/01					
Hib (Under Age 5)	DTP-HIB 06/06/97	HIB 06/16/97	HIB 01/14/98						
Measles	MMR 01/14/98	MMR 03/07/01							
Mumps	MMR 01/14/98	MMR 03/07/01							
Rubella	MMR 01/14/98	MMR 03/07/01							
PCV	PCV7 03/07/01								
Varicella	VAR 01/14/98								

Recommended Vaccines									
HepA									
HepB	HEP B 12/29/96	HEP B 03/07/97	HEP B 06/16/97						
HPV	HPV (GARDASIL) 09/26/06	HPV (GARDASIL) 05/11/07							
MCV or MPSV	MCV4 (MCV4) 02/12/09								
Rotavirus									

NOTES:

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Clinic Name: FPHC - AIELLO BUSKEY
MEDICALAddress: 424 SOUTH WILSON AVE
PRICHARD 36610

Telephone #: (251) 452-1442

Certified by (Signature)

6/28/2012

Date of Issue