

**Alabama Department of Public Health****CERTIFICATE OF IMMUNIZATION**

05/16/2026

Date of Expiration**(Next Required Immunization)**

ANSLEY RAE LEJEUNE (11949047)

Child's Name (first, middle, last)

11/16/2004

Birthdate

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	DTAP-HEP B- IPV 01/18/05	DTAP-HEP B- IPV 03/16/05	DTAP-HEP B- IPV 05/17/05	DTP 10/04/06	DTP 05/27/10				
TD									
Tdap	TDAP 05/16/16								
IPV,OPV	DTAP-HEP B- IPV 01/18/05	DTAP-HEP B- IPV 03/16/05	DTAP-HEP B- IPV 05/17/05	IPV 05/27/10					
Hib (Under Age 5)	HIB 01/18/05	HIB 03/16/05	HIB 05/17/05	HIB 10/04/06					
Measles	MMRV 12/05/05	MMRV 05/27/10							
Mumps	MMRV 12/05/05	MMRV 05/27/10							
Rubella	MMRV 12/05/05	MMRV 05/27/10							
PCV	PCV7 01/18/05	PCV7 03/16/05	PCV7 05/17/05	PCV7 10/04/06					
Varicella	MMRV 12/05/05	MMRV 05/27/10							

Recommended Vaccines									
HepA	HEP A 05/01/13								
HepB	HEP B 11/19/04	DTAP-HEP B- IPV 01/18/05	DTAP-HEP B- IPV 03/16/05	DTAP-HEP B- IPV 05/17/05					
HPV									
MCV, MPSV,MENB									
Rotavirus									
Covid-19									

Site Name : AUTAUGA CO HLTH DEPTAddress: 219 N COURT ST PRATTVILLETelephone #: (334) 36137433/3/2023



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Ansley LeJeune

Date of Birth: 11-16-2004

Student Number: S00435547

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: Ansley LeJeune

Date: 07-18-23

Provider Signature: J. Hinton, CNP

Date: 7/18/23