

AUM Student Health Services

Immunization Record

Patient Name: Allison Walton

Birthdate: 12/25/88

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap	8/18/23	(L) deltoid im	LOT: DD7F7 EXP: 12/06/25 NDC 58160-942-43 Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX 0.5 mL Mfr. by GlaxoSmithKline Biologicals 496018			8/16/21	ms
Td Booster							
MMR							
HEP A							
HEP B							
Other							

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

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



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Allison Walton DOB: 12-25-88 Phone: (334) 233-2027

Mailing Address: 3333 Ridgefield Drive City: Montgomery ST: AL Zip: 36106

Insurance Company: BCBS Subscriber name: _____ DOB: _____

Insurance Contract Number: _____ Group number: _____

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 _____	☐	☒	☐
3) Have you had any serious reactions from a vaccine?	☐	☒	☐
4) Have you been diagnosed with Guillain-Barre syndrome?	☐	☒	☐

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 Albi Date 8/18/23

Administration Date 8/18/23 Route: IM LD or RD Volume: 0.5ml

Administrator M. Bicknell VIS Date 08/06/2021

Manufacturer: GSK Fluarix® Quadrivalent Lot # G2ML4 Expires 06/30/2024

Temp: 98.1

LOT: G2ML4
EXP: 06/30/24
NDC 58160-909-41
Rx Only
Influenza
Vaccine
FLUARIX QUADRIVALENT
2023/2024 Formula
0.5 mL

Mfg. by
GlaxoSmithKline
Biologicals

514456



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Walters

FIRST NAME: Arlis M

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: unknown

DATE OF MOST RECENT BOOSTER: 8/18/2023

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CRNA

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

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INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Allison Walton FIRST NAME: Allison 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: 8/18/23 MANUFACTURER: GSK LOT #: 62rnl4 EXPIRATION DATE: 6/30/24

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

PROVIDER - PLEASE PRINT THE FOLLOWING INFORMATION:

NAME OF PERSON ADMINISTERING: m. Richardson CREDENTIALS OF PERSON ADMINISTERING: RN

SIGNATURE OF PERSON ADMINISTERING: [Signature] RN

NAME OF OFFICE OR FACILITY: AUM PHONE #: (334) 244-3281

STREET ADDRESS: 7461 East Dr. CITY: Montgomery STATE: AL ZIP CODE: 36117

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VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: WALTON

FIRST NAME: ALLISON

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: 8/14/2023 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Ramin 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 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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HEPATITIS B IMMUNIZATION

LAST NAME: Walton

FIRST NAME: Allison

TSCC 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: 8/18/23 POSITIVE? ☒ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? _____ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER 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: _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
Please place office stamp
here (if possible) for
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2ND VACCINATION DATE: _____
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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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 ✓)

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Allison Walton

DATE OF BIRTH 12 / 25 / 88
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 Allison Walton DATE 8/18/23

FORM REVIEWED BY CHB RN DATE 9/18/23

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.