

**AUM Student Health Services
Immunization Record**

Patient Name: Chrisyana Finkku

Birthdate: 12/18/02

Allergies/Medical Alert: NA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
<u>Tdap</u>	<u>12/4/23</u>	<u>Deltoid</u>		LOT: NR5DX EXP: 02/02/26		<u>8/10/21</u>	<u>WBS</u>
		<u>1m</u>		NDC 58160-842-43			
Td Booster				Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX	0.5 mL		
				Mfr. by GlaxoSmithKline Biologicals			
MMR					496018		
HEP A							
<u>HEP B</u>	<u>12/4/23</u>	<u>Deltoid</u>		LOT: XS27B EXP: 03/17/25		<u>5/12/03</u>	<u>WBS</u>
		<u>1m</u>		NDC 58160-821-43			
				Hepatitis B Vaccine (Recombinant)			
Other				ENGERIX-B	20 mcg/mL		
				Mfr. by GlaxoSmithKline Biologicals			

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID				<u>Sunofi</u>	<u>2CA93C1</u>	<u>exp 10/26</u>	

Initials	Signature	Initials	Signature

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

STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Chrisyona Finklea

DATE OF BIRTH 12 / 18 / 2007
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?	☒	☐	☐

COVID 11/28/23

FORM COMPLETED BY Chrisyona Finklea DATE 11/4/23

FORM REVIEWED BY [Signature] DATE 12/14/2023

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.