



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Montgomery

FIRST NAME: Shaderrick

TSCC ID #: A02250737

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

HAVE YOU RECEIVED YOUR MMR IMMUNIZATION IN THE PAST? 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-VACCINATION IS REQUIRED.

DATE OF MEASLES (RUBEOLA) TITER: _____ POSITIVE? _____ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)

DATE OF MUMPS TITER: _____ POSITIVE? _____ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)

DATE OF RUBELLA (MEASLES) TITER: _____ POSITIVE? _____ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.7 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

Provider:
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here (if possible) for
validation purposes.

IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!
IF TITER RESULTS ARE NEGATIVE OR IF YOU HAVE NEVER BEEN VACCINATED - 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. A HEALTHCARE PROVIDER MAY RECOMMEND A BOOSTER. IF A BOOSTER IS PERFORMED COMPLETE DOSE #1 LINE ITEM.

DOSE # 1	MEASLES (RUBEOLA)	DATE: <u>3/16/95</u>	DOSE # 2	MEASLES (RUBEOLA)	DATE: <u>3/16/98</u>
DOSE # 1	MUMPS	DATE: <u>3/16/95</u>	DOSE # 2	MUMPS	DATE: <u>3/16/98</u>
DOSE # 1	RUBELLA (MEASLES)	DATE: <u>3/16/95</u>	DOSE # 2	RUBELLA (MEASLES)	DATE: <u>3/16/98</u>

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE L. Barton, CNP

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validation purposes.

AFTER COMPLETION OF STEP 2 (2-DOSE SERIES) OR BOOSTER, HAVE A TITER DRAWN FOR EACH VACCINATION RECEIVED IN STEP 2 TO DOCUMENT IMMUNITY:

DATE OF MEASLES TITER: 11/21/23 POSITIVE? _____ NEGATIVE? ☒ (please identify results with a ✓)

DATE OF MUMPS TITER: 11/21/23 POSITIVE? _____ NEGATIVE? ☒ (please identify results with a ✓)

DATE OF RUBELLA TITER: 11/21/23 POSITIVE? ☒ NEGATIVE? _____ (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE L. Barton, CNP



HEPATITIS B IMMUNIZATION

LAST NAME: Montgomery

FIRST NAME: Shaderrick

TSCC ID #: 102250737

HAVE YOU COMPLETED A SERIES OF HEPATITIS B IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

HEPATITIS B TITER - TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER.

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

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

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: 3/4/94

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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2ND VACCINATION DATE: 4/4/94
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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3RD VACCINATION DATE: 9/14/94
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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AFTER COMPLETION OF THE FULL 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B ANTIBODY TO DOCUMENT IMMUNITY:

DATE OF TITER: 11/21/23 POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? $\checkmark$ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Montgomery

FIRST NAME: Shaderrick

TSCC ID #: A12251237

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

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

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 HAD A VARICELLA/CHICKEN POX VACCINATION OR A NEGATIVE TITER RESULT - VARICELLA IMMUNIZATION OR BOOSTER IS REQUIRED. A HEALTHCARE PROVIDER MAY RECOMMEND A BOOSTER. IF A BOOSTER IS PERFORMED COMPLETE VACCINATION #1 ONLY.

VARICELLA/CHICKEN POX VACCINE

DATE OF VARICELLA VACCINE #1: 8/10/2001

DATE OF VARICELLA VACCINE #2: 3/5/09

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider:
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AFTER COMPLETION OF 2-PART SERIES OR BOOSTER, HAVE A TITER DRAWN FOR VARICELLA ANTIBODY TO DOCUMENT IMMUNITY:

DATE OF TITER: 11/21/23 POSITIVE? ☒ NEGATIVE? ☐ (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]



INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Montgomery

FIRST NAME: Shaderrick

TSCC ID #: A02250737

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: 11/21/23 MANUFACTURER: GSK LOT #: G2ML4 EXPIRATION DATE: 6/30/2024

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

PROVIDER - PLEASE PRINT THE FOLLOWING INFORMATION:

NAME OF PERSON ADMINISTERING: Lindsey Burtin CREDENTIALS OF PERSON ADMINISTERING: CNP

SIGNATURE OF PERSON ADMINISTERING: [Signature]

NAME OF OFFICE OR FACILITY: Norhank Health Services PHONE #: 334-244-3281

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

AUBURN UNIVERSITY MONTGOMERY

STUDENT HEALTH CENTER

IRMA B. MOORE HALL RM. 102

Please place office stamp

here (if possible) for

validation purposes.



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: ShaDerrick Montgomery DOB: 03/04/1994 Phone: 334-313-6312

Mailing Address: 147 Meadowview Dr City: Elmore ST: AL Zip: 36025

Insurance Company: Self 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 ShaDerrick Montgomery Date 11/21/23

Administration Date 11/21/23 Route: IM (LD or RD) Volume: 0.5ml

Administrator J. Banton, CNA VIS Date 08/06/2021

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

Temp: 96.8

LOT: G2ML4
EXP: 06/30/24

NDC 58160-909-41
Rx Only
Influenza
Vaccine
FLUARIX QUADRIVALENT
2023/2024 Formula

Mfd. by
GlaxoSmithKline
Biologicals

514456



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Montgomery

FIRST NAME: Shaderrick

TSCC ID #: A02250737

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: 8/1/05

DATE OF MOST RECENT BOOSTER: 11/21/23

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT)

Lindsey Barton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

[Signature]

Provider
AUBURN UNIVERSITY MONTGOMERY
Please place official stamp
here if possible for
validation purposes.
MOORE HALL RM. 102
PO BOX 244023
MONTGOMERY, AL 36102-4023



Rt. Delt. Im

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME ShaDerrick Montgomery
DATE OF BIRTH 03 / 04 / 1994
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 ShaDerrick Montgomery DATE 11/21/23
FORM REVIEWED BY J. Benton, CLP DATE 11/21/23

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.