



HEPATITIS B IMMUNIZATION

LAST NAME: Thacker

FIRST NAME: William

TSCC ID #: _____

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: 11/29/25 POSITIVE? _____ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? ☒ (anti-HBs ≤ 10 mIU/mL) (please identify results with a ☒)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

Lindsey Barton, CNP

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

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

**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: 12/15/2023

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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Ident. LOT: XS27B
EXP: 03/17/25
NDC 58160-921-43
Hepatitis B
Vaccine
(Recombinant)
ENGRIX-B 20 mcg/mL
Mfd. by
GlaxoSmithKline
Biologicals
495702

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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3RD VACCINATION DATE: _____
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: _____ POSITIVE? _____ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? _____ (anti-HBs ≤ 10 mIU/mL) (please identify results with a ☒)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Trucker

FIRST NAME: William

TSCC ID #: _____

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: 11/29/23 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)
DATE OF MUMPS TITER: 11/29/23 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)
DATE OF RUBELLA (MEASLES) TITER: 11/29/23 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

[Handwritten Signature]

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MONTGOMERY, AL 36124-4023

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: _____	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 _____

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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: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a ✓)
DATE OF MUMPS TITER: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a ✓)
DATE OF RUBELLA TITER: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Thacker

FIRST NAME: William

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: 11/29/23 POSITIVE? ____ (≥ 1.1 AI) NEGATIVE? ☒ (≤ 0.8 AI) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

[Handwritten 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: 12/15/2023

DATE OF VARICELLA VACCINE #2: _____

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

[Handwritten Signature]

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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: _____ POSITIVE? ____ NEGATIVE? ____ (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Thacker

FIRST NAME: William

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: 11/29/23 MANUFACTURER: GSK LOT #: 62ML4 EXPIRATION DATE: 01/30/24

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

PROVIDER - PLEASE PRINT THE FOLLOWING INFORMATION:

NAME OF PERSON ADMINISTERING: Miranda Bicknell CREDENTIALS OF PERSON ADMINISTERING: RN

SIGNATURE OF PERSON ADMINISTERING: [Signature] RN

NAME OF OFFICE OR FACILITY: AUM - Wauhatch Health PHONE #: 334-244-3281

STREET ADDRESS: 7401 East Dr. CITY: Montgomery STATE: AL ZIP CODE: 36117

Provider:
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**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: William Thacker DOB: 01/22/97 Phone: 334-676-9622

Mailing Address: 8572 Old Marsh Way City: Montgomery ST: AL Zip: 36117

Insurance Company: BCBS Subscriber name: William Thacker DOB: 01/22/97

Insurance Contract Number: PPA870248090 Group number: 51942

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 <u>demerol</u>	☒	☐	☐
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 Will Thacker Date 11/29/23

Administration Date 11/29/23 Route: IM LD or RD Volume: 0.5ml

Administrator M. Bicknell, RN VIS Date 08/06/2021

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

Temp: 99.0



Mfd. by
GlaxoSmithKline
Biologicals

0.5 mL

514456



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Thacker

FIRST NAME: William

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: 3/24/97
D Tap.

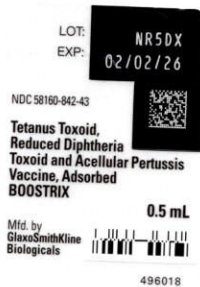
DATE OF MOST RECENT BOOSTER: 11/29/2023

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT)

Lindsey Barton, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

L. Barton, CRNP



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**AUM Student Health Services
Immunization Record**

Patient Name: William Thacker

Birthdate: 11/22/1997

Allergies/Medical Alert:

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
<u>Tdap</u>	11/29/23	(R) Deltoid	0.5ml	GSK	1st dose	8/10/21	WTS
		1m		1st dose	5th		
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
WTS	WTS		

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STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME William Thacker

DATE OF BIRTH 01 / 22 / 97
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? <u>demerol</u>	☒	☐	☐
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 William Thacker DATE 12/5/23

FORM REVIEWED BY MS in OPEN DATE 12/5/23

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.

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME William Thacker

DATE OF BIRTH 01 / 22 / 1997
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 William Thacker DATE 11/29/2023

FORM REVIEWED BY [Signature] RN DATE 11/29/23

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.