

AUM Student Health Services

Immunization Record

Patient Name: Zekaira Lowery

Birthdate: 11/26/99

Allergies/Medical Alert: N/A

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
<u>Tdap</u>	<u>11/8/2024</u>	<u>Upper arm</u>		LOT: P5SR5 EXP: 04/26/26 NDC 58160-942-43 Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX Mfg. by GlaxoSmithKline Biologicals		<u>8/16/21</u>	<u>MS</u>
Td Booster					0.5 mL		
MMR					496018		
HEP A							
<u>HEP B</u>	<u>1-11-24</u>	<u>Upper arm</u>		LOT: XS27B EXP: 03/17/25 NDC 58160-821-43 Hepatitis B Vaccine (Recombinant) ENGRIX-B Mfg. by GlaxoSmithKline Biologicals		<u>5/12/23</u>	<u>MS</u>
Other					20 mcg/mL		

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

Initials	Signature	Initials	Signature
<u>MS</u>	<u>MS</u>		

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P.O. BOX 244023
MONTGOMERY, AL 36124-4023

STAMP ABOVE



HEPATITIS B IMMUNIZATION

LAST NAME: Lowery

FIRST NAME: Zekaira

TSSC 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: 11/8/24 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, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

Provider:
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validation purposes.

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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: 11/12/24

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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

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3RD VACCINATION DATE _____
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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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 ✓)



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Conley

FIRST NAME: Zekaiya

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: 11/8/24 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Lindsey Barton, 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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MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Lawley

FIRST NAME: Zabrina

TSCC ID #: _____

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

HAVE YOU RECEIVED YOUR MMR IMMUNIZATION? 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-IMMUNIZATION IS REQUIRED.

DOSE #1

DATE OF MEASLES (RUBEOLA) TITER: 1/8/24 POSITIVE? (≥ 1.1 AI) ☒ NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE? ☒
DATE OF MUMPS TITER: 1/8/24 (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE? ☒
DATE OF RUBELLA (MEASLES) TITER: 1/8/24 AI) NEGATIVE? (≤ 0.7 AI) (please identify results with a ✓) POSITIVE? ☒

positive immunity for mme

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!
IF TITER RESULTS ARE NEGATIVE - 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.

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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TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Lowery

FIRST NAME: Zekaiya

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: 7/8/2011

DATE OF MOST RECENT BOOSTER: 1/8/24

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

[Handwritten signature: Lindsey Barton, CRNP]

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INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Lamery

FIRST NAME: Zekairyu

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: 11/8/24 MANUFACTURER: GSK LOT #: 62mL4 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: Miranda Bicknell 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
Suite 102

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**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Ze'Kairya Lawery DOB: 11-26-99 Phone: 334-746-0803

Mailing Address: 9249 ~~Camp~~ Concord Park Dr City: Montgomery ST: AL Zip: 36117

Insurance Company: BCBS Subscriber name: Tikishia McCloud DOB: 08-11-78

Insurance Contract Number: PPA818633126 Group number: 37913

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: Ze'Kairya Lawery Date: 01-08-24

Administration Date: 11/8/2024 Route: IM LD of RD Volume: 0.5ml

Administrator: m. Bicknell, RN 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

Mfd. by
GlaxoSmithKline
Biologicals



514456

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Ze'kaiya Lawen

DATE OF BIRTH 11/26/99
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 Ze'kaiya Lawen DATE 01-08-24
FORM REVIEWED BY MP-RN DATE 11/9/2024

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.