



HEPATITIS B IMMUNIZATION

LAST NAME: Galloway FIRST NAME: Ashley 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: 11/17/24 POSITIVE? _____ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? ☒ (anti-HBs ≤ 10 mIU/mL) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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

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
validation purposes.

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 $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Galloway FIRST NAME: Ashley 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: 01/17/24 POSITIVE? ✓ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)
DATE OF MUMPS TITER: 01/17/24 POSITIVE? ✓ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)
DATE OF RUBELLA (MEASLES) TITER: 01/17/24 POSITIVE? ✓ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.7 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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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 _____

Provider:
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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 _____



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Galloway

FIRST NAME: Ashley

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.

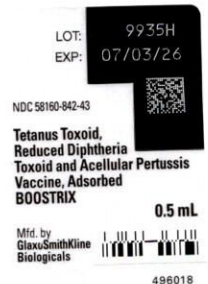
DATE OF ORIGINAL TDAP VACCINATION: 12/30/91
DTp

DATE OF MOST RECENT BOOSTER: 01/14/2024

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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





VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Galloway FIRST NAME: Ashley 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: 11/17/24 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

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PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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

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: _____

DATE OF VARICELLA VACCINE #2: _____

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

Provider:
Please place office stamp
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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 ☒)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: GALLOWAY, ASHLEY N
 DOB: 09-24-1991
 Chart #:
 Date of Service: 06-14-2024

Vaccine Family	Type of Vaccine (no Brand Name)	Date Given (mm/dd/yy)	Age at Adm	Dose (cc/mL)	Route & Site	Mfr.	Lot #	VIS Date	Vaccinator Signature
Tetanus, Diphtheria, (Pertussis) (e.g., Td, Tdap)	DTP	12/30/91	3 m	0.5					
	DTP	02/27/92	5 m	0.5					
	DTP	04/14/92	6 m	0.5					
	DTP	06/11/96	4 y	0.5					
	TD	08/01/06	14 y	0.5					OUTSIDE CLINIC
Hepatitis A (e.g., HepA, HepA-HepB)									
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B UNS	01/11/93	15 m	0.5					
	HEP B UNS	06/11/96	4 y	0.5					
	HEP B UNS	08/01/06	14 y	0.5					OUTSIDE CLINIC
Human Papillomavirus (e.g., HPV)	HPV (GARDASIL)	07/08/15	23 y	0.5		MSD			
	HPV (GARDASIL)	09/08/15	23 y	0.5		MSD			
Measles, Mumps, Rubella (MMR, MMRV)	MMR	01/11/93	15 m	0.5					
	MMR	06/11/96	4 y	0.5					
Meningococcal (MCV4, MPSV4)									
Pneumococcal (e.g. PCV, PPV)									
Polio (e.g., IPV, DTaP-HepB-Hib)	OPV	12/30/91	3 m	0.5					
	OPV	02/27/92	5 m	0.5					
	OPV	06/11/96	4 y	0.5					
Varicella (Var, MMRV)	Varicella Disease History	10/15/93							
Influenza (e.g., TIV, LAIV)	IIV4 - P FREE	10/24/19	28 y	0.5	IM RA	SKB	425T2		OUTSIDE CLINIC
Zoster									
Other	HIB UNS	12/30/91	3 m	0.5					
	HIB UNS	02/27/92	5 m	0.5					
	HIB UNS	01/11/93	15 m	0.5					
	J&J Covid19	07/10/21	29 y	0.5	IM RD	JSN	043A21A		OUTSIDE CLINIC
	Moderna COVID-19 Vaccine	01/11/22	30 y	0.5	IM LD	MOD	016J21-2A		OUTSIDE CLINIC

WARHAWK HEALTH SERVICES
 7461 EAST DRIVE
 RM 102 MOORE HALL
 MONTGOMERY, AL36117
 334 2443281

PPD	Date	Results	PPD	Date	Results
Mantoux			Maxtoux		
Mantoux			Mantoux		
Mantoux			Mantoux		

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Ashley Galloway
DATE OF BIRTH 09 / 24 / 1991
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>e.g. sticky pads & sulfer drugs</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 Ashley Galloway DATE 6/14/2024
FORM REVIEWED BY [Signature] DATE 6/14/2024

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.



Patient Information	Specimen Information	Client Information
GALLOWAY, ASHLEY DOB: 09/24/1991 AGE: 32 Gender: F Phone: 256.441.1265 Patient ID: 5368 Health ID: 8573017959536644	Specimen: AZ529050H Requisition: 0002564 Lab Ref #: 01011611 Collected: 06/17/2024 / 10:25 CDT Received: 06/18/2024 / 00:32 CDT Reported: 06/18/2024 / 15:20 CDT	Client #: 49100638 QATL0000 BARTON, LINDSEY AUM NURSING CARE CENTER 7461 EAST DRIVE #102 MONTGOMERY, AL 36117

Test Name	In Range	Out Of Range	Reference Range	Lab
MEASLES, MUMPS, AND RUBELLA (MMR) AB (IGG) PANEL, IMMUNE STATUS				

MEASLES AB (IGG), IMMUNE STATUS	>300.00		AU/mL	AT
AU/mL	Interpretation			
-----	-----			
<13.50	Not consistent with immunity			
13.50-16.49	Equivocal			
>16.49	Consistent with immunity			

The presence of measles IgG suggests immunization or past or current infection with measles virus.

For additional information, please refer to
<http://education.QuestDiagnostics.com/faq/FAQ162>
(This link is being provided for informational/
educational purposes only.)

MUMPS VIRUS AB (IGG), IMMUNE STATUS	54.10		AU/mL	AT
AU/mL	Interpretation			
-----	-----			
<9.00	Not consistent with immunity			
9.00-10.99	Equivocal			
>10.99	Consistent with immunity			

The presence of mumps IgG antibody suggests immunization or past or current infection with mumps virus.

RUBELLA AB (IGG), IMMUNE STATUS	7.83		Index	AT
Index	Interpretation			
-----	-----			
<0.90	Not consistent with immunity			
0.90-0.99	Equivocal			
> or = 1.00	Consistent with immunity			

The presence of rubella IgG antibody suggests immunization or past or current infection with rubella virus.

VARICELLA ZOSTER VIRUS ANTIBODY (IGG)	3203.00		index	AT
Index	Interpretation			
-----	-----			
<135.00	Negative - Antibody not detected			
135.00 - 164.99	Equivocal			
> or = 165.00	Positive - Antibody detected			

A positive result indicates that the patient has antibody to VZV but does not differentiate between an active or past infection. The clinical diagnosis must be interpreted in conjunction with the clinical signs and symptoms of the patient. This assay reliably measures immunity

Patient Information	Specimen Information	Client Information
GALLOWAY, ASHLEY DOB: 09/24/1991 AGE: 32 Gender: F Patient ID: 5368 Health ID: 8573017959536644	Specimen: AZ529050H Collected: 06/17/2024 / 10:25 CDT Received: 06/18/2024 / 00:32 CDT Reported: 06/18/2024 / 15:20 CDT	Client #: 49100638 BARTON, LINDSEY

Test Name	In Range	Out Of Range	Reference Range	Lab
due to previous infection but may not be sensitive enough to detect antibodies induced by vaccination. Thus, a negative result in a vaccinated individual does not necessarily indicate susceptibility to VZV infection. A more sensitive test for vaccination-induced immunity is Varicella Zoster Virus Antibody Immunity Screen, ACIF.				

PENDING TESTS:

HEPATITIS B SURFACE AB IMMUNITY, QN

PERFORMING SITE:

AT QUEST DIAGNOSTICS-ATLANTA, 1777 MONTREAL CIRCLE, TUCKER, GA 30084-6802 Laboratory Director: ANDREW N YOUNG, MD, PHD, CLIA: 11D0255931