



## 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: 6/17/24 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) Lindsey Barton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

AUBURN UNIVERSITY MONTGOMERY  
STUDENT HEALTH CENTER  
IRMA B. MOORE HALL RM. 102  
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 COMPLETED A HEPATITIS B IMMUNIZATION OR IF YOU HAD A NEGATIVE TITER - A FULL 3-PART SERIES IMMUNIZATION IS REQUIRED.

1ST VACCINATION DATE: 6/28/24

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: [Signature], RN

AUBURN UNIVERSITY MONTGOMERY  
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P.O. BOX 244023  
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2ND VACCINATION DATE: \_\_\_\_\_  
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: \_\_\_\_\_

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

3RD VACCINATION DATE: \_\_\_\_\_  
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: \_\_\_\_\_

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

**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  $\geq 10$  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 \_\_\_\_\_



# 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?                                                                                                                                                                                                                                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have allergies to medications, food, a vaccine component, or latex?<br><i>e.g. sticky pads &amp; sulfee drugs</i>                                                                                                                                        | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction after receiving a vaccination?                                                                                                                                                                                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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?                                                                                           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?                                                                                                                                                                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a seizure or a brain or other nervous system problem?                                                                                                                                                                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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?                                                                                                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?                                                                                                                                                               | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you received any vaccinations in the past 4 weeks?                                                                                                                                                                                                        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

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.