



HEPATITIS B IMMUNIZATION

LAST NAME: Williamson

FIRST NAME: Anzley

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: 10/14/24 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, 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.

#1

LOT: 4T39P
EXP: 12/09/25

NDC 58160-821-43

Hepatitis B
Vaccine
(Recombinant)
ENGIRIX-B

20 mcg/mL

Mfd by
GlaxoSmithKline
Biologicals

495702

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: 10/28/24

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: [Signature]

AUBURN UNIVERSITY MONTGOMERY

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P.O. BOX 244023

MONTGOMERY, AL 36124-4023

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 ≥ 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 _____



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Ferrari

FIRST NAME: Anzley

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.

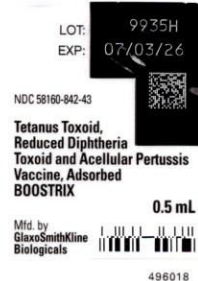
DATE OF ORIGINAL TDAP VACCINATION: 5/14/97
DTP

DATE OF MOST RECENT BOOSTER: 06/28/2024

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE L. Barton, CRNP

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.



(L) Delt.
1m

ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: WILLIAMSON, ANZLEY

DOB: 03-13-1997

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-HIB	05/14/97	2 m	0.5					
	DTAP	08/11/97	4 m	0.5					
	DTAP	10/14/97	7 m	0.5					
	DTAP	06/15/98	15 m	0.5					
	DTAP	03/28/01	4 y	0.5					
	TDAP	10/27/08	11 y	0.5					
	TDAP	01/01/14	16 y	0.5					
Hepatitis A (e.g., HepA, HepA-HepB)									
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B UNS	04/11/97	0 m	0.5					
	HEP B UNS	05/14/97	2 m	0.5					
	HEP B UNS	02/04/98	10 m	0.5					
Human Papillomavirus (e.g., HPV)									
Measles, Mumps, Rubella (MMR, MMRV)	MMR	03/17/98	12 m	0.5					
	MMR	08/12/02	5 y	0.5					OUTSIDE CLINIC
Meningococcal (MCV4, MPSV4)	MCV4P (MENACTRA)	03/01/10	12 y	0.5					OUTSIDE CLINIC
Pneumococcal (e.g. PCV, PPV)									
Polio (e.g., IPV, DTaP-HepB-Hib)	OPV	05/14/97	2 m	0.5	PO				
	OPV	08/11/97	4 m	0.5	PO				
	OPV	06/15/98	15 m	0.5	PO				
	IPV	03/28/01	4 y	0.5					
Varicella (Var, MMRV)	VARICELLA	03/17/98	12 m	0.5					
	VARICELLA	03/01/10	12 y	0.5					OUTSIDE CLINIC
Influenza (e.g., TIV, LAIV)	INFLUENZA UNS	11/30/05	8 y	0.25 0.5					
	INFLUENZA UNS	11/15/07	10 y	0.25 0.5					
	INFLUENZA UNS	10/27/08	11 y	0.25 0.5					
Zoster									
Other	HIB UNS	08/11/97	4 m	0.5					
	HIB UNS	10/14/97	7 m	0.5					
	HIB UNS	06/15/98	15 m	0.5					
	Pfizer Covid19	03/30/21	24 y	0.3	IM RD	PFR	EN6205		OUTSIDE CLINIC
	Pfizer Covid19	04/20/21	24 y	0.3	IM RD	PFR	EN6205		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 Anzley Ferrari
DATE OF BIRTH 3 / 13 / 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?	☐	☒	☐
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 Anzley Ferrari DATE 6/28/24
FORM REVIEWED BY [Signature] DATE 6/28/24

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.