



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Perez Suarez

FIRST NAME: Leslie

TSCC ID #: A02477252

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: 6/24/24 POSITIVE? ✓ (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓)
DATE OF MUMPS TITER: 6/24/24 POSITIVE? ✓ (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓)
DATE OF RUBELLA (MEASLES) TITER: 6/24/24 POSITIVE? ✓ (≥ 1.1 AI) NEGATIVE? (≤ 0.7 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider:
Please place office stamp
here (if possible) for
validation purposes.
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 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: <u> </u>	DOSE # 2	MEASLES (RUBEOLA)	DATE: <u> </u>
DOSE # 1	MUMPS	DATE: <u> </u>	DOSE # 2	MUMPS	DATE: <u> </u>
DOSE # 1	RUBELLA (MEASLES)	DATE: <u> </u>	DOSE # 2	RUBELLA (MEASLES)	DATE: <u> </u>

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



HEPATITIS B IMMUNIZATION

LAST NAME: Perez Suarez

FIRST NAME: Leslie

TSCC ID #: A02477252

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: 10/24/24 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 [Signature]

Provider:
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STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102

IF YOUR TITER RESULTS ARE POSITIVE YOU ARE DONE!
IF YOUR RESULTS ARE NEGATIVE - COMPLETE STEP 2 BELOW.
PO BOX 244023
MONTGOMERY, AL 36124-4023

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: 7/1/2024

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: [Signature]

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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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 _____

LOT: 4T39P
EXP: 12/09/25

NDC 58160-821-43

**Hepatitis B
Vaccine
(Recombinant)**
ENGRIX-B

20 mcg/mL

Mfd. by
GlaxoSmithKline
Biologicals

495702



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Perez Suarez

FIRST NAME: Leslie

TSCC ID #: A02477252

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: 01/24/24 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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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:
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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 _____

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Leslie Perez

DATE OF BIRTH 08/08/2004
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 Leslie Perez DATE 07/01/24

FORM REVIEWED BY Debra Mangott DATE 7/1/24

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.