



12/29/00

MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Hernandez Vaguero FIRST NAME: Adayana 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: 10/29/24 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)
 DATE OF MUMPS TITER: 10/29/24 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)
 DATE OF RUBELLA (MEASLES) TITER: 10/29/24 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE L. Burton, CRNP

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

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 $\checkmark$)
 DATE OF MUMPS TITER: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a $\checkmark$)
 DATE OF RUBELLA TITER: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



12/29/00

VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Hernandez-Vaquero FIRST NAME: Adaysana 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: 10/29/2024 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 [Signature]

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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 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 ☒)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



12/29/00

HEPATITIS B IMMUNIZATION

LAST NAME: Hernandez Vaguero FIRST NAME: Adriana 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: 10/29/2024 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 Burton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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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: _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
Please place office stamp
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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
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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 _____



DOB 12/25/2000

TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Hernandez Vaguer FIRST NAME: Adaysana

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: 12/13/02

DATE OF MOST RECENT BOOSTER: 10/29/2024

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

[Handwritten Signature: Lindsey Barton, CRNP]

AUBURN UNIVERSITY MONTGOMERY
STUDENT OFFICE STAMP
IRMA B. MOORE
here (if possible) for
validation purposes
P.O. BOX 24103
MONTGOMERY, AL 36102-0103



Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME Adayana Hernandez-Vaquero
DATE OF BIRTH 12 / 25 / 2000
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 we need to ask you more questions. 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 vaccine?	☐	☒	☐
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☒	☐
7. In the past 6 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?	☐	☒	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☒	☐
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☒	☐
11. Are you pregnant?	☐	☒	☐
12. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐
13. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☒	☐
14. Are you anxious about getting a shot today?	☒	☐	☐

FORM COMPLETED BY Adayana Hernandez-Vaquero DATE 10/29/24
FORM REVIEWED BY UBC DATE 10/29/2024

Did you bring your immunization record card with you? yes ☐ no ☒

It is important 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.



ADULT IMMUNIZATION RECORD

Allergies:
Reactions:

Name: VAQUERO, ADAYOANA H
 DOB: 12-25-2000
 Chart #:
 Date of Service: 10-29-2024

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)	DTAP	02/26/01	2 m	0.5					
	DTAP	04/25/01	4 m	0.5					
	DTAP	06/26/01	6 m	0.5					
	DTAP	05/28/02	17 m	0.5					
	DTAP	11/02/06	5 y	0.5					
	TDAP	12/13/12	11 y	0.5					
Hepatitis A (e.g., HepA, HepA-HepB)	HEP A	01/08/07	6 y	0.5					
	HEP A	01/24/08	7 y	0.5					
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PED	12/25/00	0 m	0.5					OUTSIDE CLINIC
	HEP B ADOL/PED	01/25/01	1 m	0.5					
	HEP B ADOL/PED	04/25/01	4 m	0.5					
	HEP B UNS	01/29/10	9 y	0.5					
	HEP B ADOL/PED	05/09/11	10 y	0.5	IM RA	SKB	AHBVB972AA	07/18/2007	OUTSIDE CLINIC
Human Papillomavirus (e.g., HPV)	HPV (GARDASIL)	10/01/10	9 y	0.5					
	HPV (GARDASIL)	12/02/10	9 y	0.5					
	HPV (GARDASIL)	05/09/11	10 y	0.5	IM RA	MSD	0786Z	03/30/2010	OUTSIDE CLINIC
Measles, Mumps, Rubella (MMR, MMRV)	MMR	12/26/01	12 m	0.5					
	MMR	11/02/06	5 y	0.5					
Meningococcal (MCV4, MPSV4)	MENINGOCOCCAL UNS	12/13/12	11 y	0.5					
	MENINGOCOCCAL UNS	04/05/17	16 y	0.5					
Pneumococcal (e.g. PCV, PPV)	PCV7	02/26/01	2 m	0.5					
	PCV7	04/25/01	4 m	0.5					
	PCV7	06/26/01	6 m	0.5					
	PCV7	09/26/01	9 m	0.5					
Polio (e.g., IPV, DTaP-HepB-Hib)	IPV	02/26/01	2 m	0.5					
	IPV	04/25/01	4 m	0.5					
	IPV	06/26/01	6 m	0.5					
	IPV	11/02/06	5 y	0.5					
Varicella (Var, MMRV)	VARICELLA	12/26/01	12 m	0.5					
	VARICELLA	01/24/08	7 y	0.5					
	Positive Varicella Titer	01/29/10							
Influenza (e.g., TIV, LAIV)	INFLUENZA UNS	11/13/02	22 m	0.25 0.5					
	INFLUENZA UNS	12/29/03	3 y	0.25 0.5					
	INFLUENZA UNS	10/01/10	9 y	0.25 0.5					
Zoster									
Other	HIB (HBOC)	02/26/01	2 m	0.5					
	HIB (HBOC)	04/25/01	4 m	0.5					
	HIB (HBOC)	06/26/01	6 m	0.5					
	HIB (HBOC)	05/28/02	17 m	0.5					

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		