



Hepatitis A and B

Date: 10/8/2018

Dear Mr and Mrs. Byrom:

Your final Hepatitis A and B vaccine is now due.

Please call the Nursing Care Center for an appointment as soon as possible at 244-3281.

Thank you for allowing us to participate in the protection of your good health.

Sincerely,

Amy Morris, BSN RN-BC

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Kimberly Byrom
DATE OF BIRTH 01/15/73
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 Kimberly Byrom DATE 5.18.18

FORM REVIEWED BY _____ DATE _____

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.

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME

Kimberly Byrom

DATE OF BIRTH

11 / 15 / 73
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? <i>Loratab</i>	☒	☐	☐
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., <u>diabetes</u>), 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

Kimberly Byrom

DATE

4.13.2018

FORM REVIEWED BY

[Signature]

DATE

4/13/18

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.

ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: _____

Name: Kimberly Byrom

Date of Birth: 11/15/73 Record #: _____

Allergies: Lortab Reactions: _____

History of Chickenpox? **YES** or **NO** If yes, date if known: _____

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf Abbr*	Lot Number	Dose	Admin Site**	Route	Provider or Outpatient
	Mo	Day	Yr		Type	Mo	Yr						
Td					Td					0.5cc		IM	NDC 58160-815-43
Td					Td					0.5cc		IM	Hepatitis A & Hepatitis B (Recombinant) Vac
Td					Td					0.5cc		IM	TWINRIX®
Td					Td					0.5cc		IM	Mfd. by GlaxoSmithKline Biologicals
Tdap	4	13	18		Tdap	2	15			0.5cc	LD	IM	AM
Hep B + HepA	4	13	18		Hep B	7	16			0.0	RD	IM	AM
Hep B + HepA	5	18	18		Hep B	7	10			1.0	LD	IM	AM
Hep B					Hep B							IM	
Hep B (booster if needed)					Hep B					1 mL		IM	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV					0.5cc		IM	
Hepatitis A					Hep A							IM	
Hepatitis A					Hep A							IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
MCV4					Mening							IM	
MPSV4					Mening							SQ	

* Manufacturers: M= Merck; S = Sanofi Pasteur; W = Wyeth; G = GlaxoSmithKline

** Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm, LD = Left Deltoid, RD = Right Deltoid

*** VIS Language given, if not English: _____

[illegible][illegible][illegible][illegible]

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

AUBURN MONTGOMERY
STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023
(334) 244-3281

Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

Darlene Pierce, C.R.N.P.
Lic. #1-134315
RX: 3692

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Name Kimberly Byrom

Date 4/13/18

Address _____

R

Aralen ~~400mg~~ 500mg

Disp: 7

Sig: Take one pill every 7 days. Begin 2 wks before departure, continue through stay and for four weeks after return.

Label all prescriptions

Refill: 1 2 3 5 PRN NR

M. Fuentes, M.D., M.D. or C.R.N.P.
Product Selection Permitted

Dispense As Written

Carol Stewart, C.R.N.P.
Lic. #1-045437
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Rx: 0703

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Lic. #1-134315
RX: 3692

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Name Charles Byrom

Date 4/13/18

Address _____

R

Aralen ~~400mg~~ 500mg

Disp: 7

Sig: Take one pill every 7 days. Begin 2 wks before departure, continue through stay and for four weeks after return.

Label all prescriptions

Refill: 1 2 3 5 PRN NR

M. Fuentes, M.D., M.D. or C.R.N.P.
Product Selection Permitted

Dispense As Written