



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Wingard

FIRST NAME: Alexis

TSCC ID #: AD1235188

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: 6/10/25 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)

DATE OF MUMPS TITER: 6/10/25 POSITIVE? ☐ (≥ 1.1 AI) NEGATIVE? ☒ (≤ 0.8 AI) (please identify results with a ✓)

DATE OF RUBELLA (MEASLES) TITER: 6/10/25 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT)

Lindsey Barton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

Lindsey Barton, CNP

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 ✓)

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: Wingard

FIRST NAME: Alexis

TSCC ID #: A012351800

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: 6/10/25 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) Lindsay Barton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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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:
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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 _____



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Wingard

FIRST NAME: Alexis

TSCC ID #: A01235198

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: 6/10/25 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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

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 _____



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Wingard

FIRST NAME: Alexis

TSCC ID #: A01235188

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: 5/8/2012

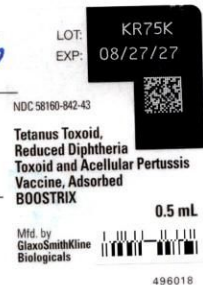
DATE OF MOST RECENT BOOSTER: 6/10/12

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT)

Lindsey Barton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

[Signature]



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Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME

Alexis Wingard

DATE OF BIRTH

4/11/90
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? <i>T1DM, hypothyroidism</i>	☒	☐	☐
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

Alexis Wingard

DATE

6/10/25

FORM REVIEWED BY

J. B. Miller, CRP

DATE

6/10/25

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.



FOR PROFESSIONALS www.immunize.org / FOR THE PUBLIC www.vaccineinformation.org

www.immunize.org/catg.d/p4065.pdf

Item #P4065 (11/6/2023)



Auburn Montgomery Student Health Services

7461 East Dr
Montgomery, AL 36117
(334) 244-3281

Laboratory Results

Patient Name: ALEXIS WINGARD

Order Date: 06/10/2025

MRN: 5456

DOB: 04/11/1998

Phone: (251) 223-9107

Gender: FEMALE

Placer Order ID: 2587458

Physician: BARTON

Filler Order ID:

Physician ID: 1215285879

Specimen Date: 06/10/2025 10:55 AM

Fasting: N

Result Date: 06/11/2025 2:10 PM

Disposition:

Specimen Source:

MEASLES/MUMPS/RUBELLA IMMUNITY				058495	STATUS: F
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Test Name	Abnormal	Result Value	Unit of Measure	Ref Range	Status	Producer ID
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RUBELLA ANTIBODIES, IGG		3.16	index	Immune >0.99	F	01
			Non-immune	<0.90		
			Equivocal	0.90 - 0.99		
			Immune	>0.99		

MEASLES ANTIBODIES, IGG		175.0	AU/mL	Immune >16.4	F	01
			Negative	<13.5		
			Equivocal	13.5 - 16.4		
			Positive	>16.4		

Presence of antibodies to Rubeola is presumptive evidence of immunity except when acute infection is suspected.

MUMPS ABS, IGG	LOW	10.9	AU/mL	Immune >10.9	F	01
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A second sample should be collected and tested no less than 2-4 weeks.

Negative	<9.0
Equivocal	9.0 - 10.9
Positive	>10.9

A positive result generally indicates past exposure to Mumps virus or previous vaccination.

HEPATITIS B SURF AB QUANT				006530	STATUS: F
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Test Name	Abnormal	Result Value	Unit of Measure	Ref Range	Status	Producer ID
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HEPATITIS B SURF AB QUANT	LOW	<3.5	mIU/mL	Immunity> 10	F	01
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Status of Immunity	Anti-HBs Level
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Inconsistent with Immunity	0.0 - 10.0
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Consistent with Immunity	>10.0
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VARICELLA-ZOSTER V AB, IGG				096206	STATUS: F
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Test Name	Abnormal	Result Value	Unit of Measure	Ref Range	Status	Producer ID
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VARICELLA ZOSTER IGG		Reactive		Non Reactive	F	01
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****Please note reference interval change****

A Reactive result is considered evidence of immunity to VZV. Reactive indicates that VZV IgG was detected consistent with previous infection and/or vaccination.

A Non Reactive result indicates that VZV IgG was not detected suggesting that immunity has not been acquired.

Lab

Confidential

Auburn Montgomery Student Health Services

7461 East Dr
Montgomery, AL 36117
(334) 244-3281

Laboratory Results

Patient Name: ALEXIS WINGARD

Order Date: 06/10/2025

MRN: 5456

DOB: 04/11/1998

Phone: (251) 223-9107

Gender: FEMALE

Placer Order ID: 2587458

Physician: BARTON

Filler Order ID:

Physician ID: 1215285879

Specimen Date: 06/10/2025 10:55 AM

Fasting: N

Result Date: 06/11/2025 2:10 PM

Disposition:

Specimen Source:

LABCORP BIRMINGHAM - 01

STEVEN WANG

1801 FIRST AVENUE SOUTH BIRMINGHAM, AL 352331935

(205) 581-3500

Lab

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Comments:

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