

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME JINGxi LI
DATE OF BIRTH JAN / 14 / 1996
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 LI JINGxi DATE APR 18 2018
FORM REVIEWED BY [Signature] DATE 4/18/18

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.

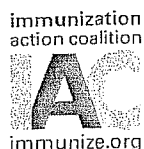
Adacel® NDC 49281-400-58
(L) C5467CA
(E) 20 JUN 2020



1 Single-dose 0.5-mL Vial
MEASLES, MUMPS, AND
RUBELLA VIRUS VACCINE LIVE
M-M-R® II
Rx only
Lot Exp.
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Whitehouse Station, NJ 08889, USA



Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

Technical content reviewed by the Centers for Disease Control and Prevention
www.immunize.org/catg.d/p4065.pdf • Item #P4065 (10/16)

Li, Jingxi

李静熙 PPD 卷

RECEIVED
JAN 11 2017

MEDICAL INFORMATION FORM
AUBURN UNIVERSITY
(CONFIDENTIAL)

MEDICAL LEGAL DOCUMENT - Property of Auburn University Medical Clinic. Information may not be released to a third party unless a proper acceptable authorization is furnished to the Medical Clinic. This release must comply with State and Federal Regulations. Incomplete or inaccurate information may delay your clearance, cancel your registration, or cause improper decisions of your future medical care.

BEFORE YOU MAIL THIS FORM, be sure to COMPLETE BOTH PAGES...Sign...Have one of your Parents/Guardians Sign

MAIL, FAX or E-Mail TO:

Auburn University Medical Clinic
ATTN: Medical Records
400 Lem Morrison Drive
Auburn University, AL 36849-5349

Phone: (334) 844-4416
Fax: (334) 528-6780

E-Mail: aumcmedrecords@aucmc.org

490060

GENERAL INFORMATION

Name: LI JINGXI Social Security # 903950nn8
Last First Middle AU User ID/GID
Home Address: _____ Student's Cell Phone: (____) - _____
City: _____ State: _____ Zip: _____
Date of Birth: 11/01/1976 Sex (circle one) M ☒ Auburn Email Address: _____
Emergency Contact - Name: Fang ZHI LING Relationship: _____
Telephone #s HOME: (____) - _____ WORK: (____) - _____ CELLULAR: (____) - _____
Address: _____
Street / P.O. Box City State Zip
Authorization for medical clinic to treat a minor student (under 19 years of age): _____
(Signature of parent or legal guardian)
List Allergies to medication or other items _____
Student Starting School: _____ Semester _____ Year _____

MEDICAL DOCUMENTATION

REQUIRED

1. TUBERCULIN SKIN TEST (PPD): This is required within six (6) months prior to the first day of class of the semester you enter school. Having a chest x-ray is NOT an acceptable alternative unless otherwise stated in Appendix A. Anyone with a new or previous positive PPD test, please refer to Appendix A on this form concerning Tuberculosis protocol.

Date PPD given: 12/27/2016 Date results read (must be no earlier than 48 hours and no later than 72 hours): 12/30/2016

Results of PPD (MUST BE DOCUMENTED IN MM - NO EXCEPTIONS): 6 x 6 mm

PLEASE, DO NOT WRITE IN THESE SPACES

Documentation / Evaluation 范正英 Fan zhengxing

M.D. Printed Name

&

M.D. Signature

OR

REQUIRED: A copy of an immunization record with your MMRs documented will be acceptable.

2. MEASLES: Measles vaccine, Live, Attenuated IS required if born after 1957. Last dose must be since 1980.

Date 12/27/2016

Type (circle):

MMR

MR

M

M.D. Printed Name

&

M.D. Signature

OR

*** (OPTIONAL) ***** (OPTIONAL) ***** (OPTIONAL) ***** (OPTIONAL) ***** (OPTIONAL) ***

3. Tetanus Toxoid - Date of last series or booster

4. Meningococcal Meningitis Vaccine - Date

5. Hepatitis B Series - Dates of Series

In the event this documentation is not easily obtainable, all of the above services can be provided at the Auburn University Medical Clinic for a fee