

**AUM NURSING CARE CENTER
IMMUNIZATION RECORD**

PATIENT NAME: James Kyle Taylor BIRTHDATE: _____

ALLERGIES/MEDICAL ALERT: _____

IMMUNIZATION	DATE	SITE	DOSE	MANUFACTURER	LOT #	COMMENTS	VIS	INITIALS
DPT								
DPaT								
DT								
Td BOOSTER								
MMR	10/6/04	① upper arm	0.5cc	Merck	0950N			JH
MR								
HIB								
HEPATITIS B								
OTHER								
TUBERCULIN TESTING PPD (MANTOUX) 0.1ml ID	DATE GIVEN	DATE READ	RESULTS	MFR	LOT #	COMMENTS		INITIALS
	10/3/04	10/6/04	Qmm	Aventis	C1954AA	① forearm		JH

INITIALS	SIGNATURE	INITIALS	SIGNATURE
JH	James Kyle Taylor		

**AUM Adult Screening and Immunization Documentation Form
2009 H1N1 Influenza Monovalent Vaccination Program**

Patient Information:	
Last Name: <u>Taylor</u>	First Name: <u>James</u>
Date of Birth: <u>5/3/1969</u>	
AUM Student/Employee ID Number: _____	E-mail Address: _____ Phone #: <u>3606</u>

Please Carefully Read and Answer the Following Questions: (circle your answer)

1	Are you between the ages of 10 and 49 years?	Yes ☒	No ☐
2	If you are between the ages of 10 and 17 years, do you take aspirin or aspirin containing medications daily? (Please inform the healthcare provider of any medications you take daily so we can carefully screen for any aspirin containing products)	Yes ☐	No ☒
3	Have you received the 2009-2010 seasonal influenza vaccine? If so, did you receive the nasal _____ or injection _____. How long has it been since this vaccination? _____ (days)	Yes ☒	No ☐
4	Do you currently feel sick or have a fever?	Yes ☐	No ☒
5	Are you taking any prescription medications to prevent or treat influenza? (Amantadine, Rimantidine, Tamiflu®, Relenza®) Have you taken any antivirals in the past 48 hours?	Yes ☐	No ☒
6	Have you ever had a serious reaction to the flu vaccine? Please describe: _____	Yes ☐	No ☒
7	Do you have an allergy to any of the following: eggs, chicken or egg protein, gentamicin, gelatin, arginine, neomycin, polymyxin B, thimerosal, formaldehyde? List any allergies: _____	Yes ☐	No ☒
8	Do you have a chronic health problem such as: heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorder?	Yes ☐	No ☒
9	Do you have an active neurological disease (a disease of the brain, nervous system, etc.)?	Yes ☐	No ☒
10	Do you have a history of Guillain-Barre Syndrome (GBS)?	Yes ☐	No ☒
11	Has your doctor ever told you that you have an immune system disorder? Are you currently taking long-term corticosteroids (prednisone, methylprednisolone, etc.); immunosuppressants; chemotherapy; biologic immune modulating medications such as Remicade®, Enbrel®, Humira®, etc? If you have an inflammatory condition such as arthritis, asthma, psoriasis, inflammatory intestinal disease, etc. Please tell the healthcare provider now.	Yes ☐	No ☒
12	Do you have HIV, cancer, or have you received an organ transplant?	Yes ☐	No ☒
13	Do you live with, care for, or have close contact with anyone who is severely immunocompromised or someone who has to be in protective environment (such as transplant patients)?	Yes ☐	No ☒
14	Have you received any vaccines in the past 30 days or do you plan to receive any vaccines in the next 4 weeks?	Yes ☐	No ☒
15	Is there any chance that you are currently pregnant?	Yes ☐	No ☒
16	Please list all of the medications that you currently take for any disease state (so the healthcare provider administering the vaccine can conduct a medication screening to ensure you are a candidate)?		

"I have read (or have had explained to me) the information in the 2009 H1N1 Influenza Monovalent Information Statement (VIS). I have also had an opportunity to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine, and I consent to receive the vaccine.

Signature _____

Date: 12/10/09

ASSESSMENT BY IMMUNIZATION CERTIFIED HEALTHCARE PROVIDER:

☒ Give injectable H1N1 flu vaccine today ☐ Give intranasal Live H1N1 flu vaccine today ☐ Do NOT give either H1N1 vaccine today	Vaccine Information Statement (VIS) Provided: ☒ Inactivated, H1N1 Influenza Monovalent Vaccine ☐ Live, H1N1 Influenza Monovalent Vaccine Interviewer's Signature: _____ Date: _____
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DOCUMENTATION OF VACCINE ADMINISTRATION

Live Intranasal H1N1 Influenza (MedImmune) NDC# 66019-200-10 Lot #: 500754P Expiration Date: January 25, 2010 Dose: 0.2 ml Route: Intranasal	Inactivated H1N1 Influenza: Manufacturer: (circle) Sanofi-Pasteur Lot#UPO22AA Exp: 4/5/2011 Novartis Lot#: 102041P1 Exp: 3/31/2011 Dose: 0.5 ml Route: IM Site: <u>Left/Right</u> Deltoid
Administered By: _____ Date: <u>12/10/09</u>	Preceptor: _____

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 SIDES...Sign...Have Your Parents Sign...Have Your Physician Sign

MAIL TO:

Auburn University Medical Clinic
Medical Records
307 West Magnolia Avenue
Auburn University, AL 36849-5349

GENERAL INFORMATION

Name: Taylor, James Kyle Social Security # 416-21-0644
Last First Middle
Home Address 7736 Steele Ridge Drive Home Phone 3342152782
City Montgomery State AL Zip 36117
Date of Birth 05/03/1969 Sex (circle one) ☒ M ☐ F Email Address jtaylor@mail.aum.edu
Emergency Contact – Name Christine Taylor Relationship Wife
Telephone #s HOME 334-215-2782 WORK 334-394-3200 CELLULAR _____
Address 7736 Steele Ridge Drive Montgomery AL 36117
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 NONE
Semester entering school (Semester / Year) FALL 2004

(REQUIRED)

MEDICAL DOCUMENTATION

1. TUBERCULIN SKIN TEST (PPD): Required within eighteen (18) months prior to the first day of class of the semester you enter school. If positive, according to Alabama Public Health Department guidelines, the chest x-ray films and an official report are required with documentation and evaluation of medical treatment if initiated or completed.

Date PPD given 10/3/04 Date results read 10/6/04

Results of PPD (report must be in mm) 0 mm

Chest x-ray results _____ Date of chest x-ray _____

Documentation / Evaluation _____

M.D. Printed Name _____

& _____ OR _____

M.D. Signature _____

AUBURN UNIVERSITY MONTGOMERY
CLINIC STAMP NURSING CARE CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023

(REQUIRED)

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

Date _____ Type (circle): ☒ MMR ☐ MR ☐ M

M.D. Printed Name _____

& _____ OR _____

M.D. Signature _____

CLINIC STAMP

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

3. Tetanus Toxoid – Date of last series or booster _____ Meningococcal Meningitis Vaccine – Date _____

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.)

INSURANCE INFORMATION

What is the name of your insurance company? BC/BS

Subscriber # See Attached

Group # _____ Plan # _____

What is your insurance company's claims address? _____

Who is the policy holder? _____

What is your relationship to the policy holder? _____

Does your plan require a co-payment? _____ If so, how much? _____

What are the limits (age, full-time status, etc.) on the policy for your coverage as a student? _____

Does your plan provide for "out of area" coverage for you? _____

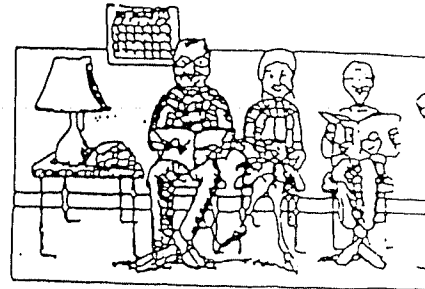
Does your plan provide for prescription benefits? _____

(Please include a legible copy of the front and back of your insurance card.)

Revised 03/02

Patient name: Kyle Taylor Date of birth: 10/6/0

Screening Questionnaire for Adult Immunization



For patients: The following questions will help us determine which vaccines may be given to you. If a question is not clear, please ask your health care provider to explain it.

	Yes	No	Do Not Know
1. Are you sick today?	☐	☒	
2. Do you have allergies to medications, food, or any vaccine?	☐	☒	
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☒	
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	☐	☒	
6. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	☐	☒	
7. For women: Are you pregnant or is there a chance you could become pregnant in the next three months?	☐	☐	
8. Have you received any vaccinations in the past 4 weeks?	☐	☒	

Form completed by: Kyle Taylor

Date 10/06/0

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 record card, your health care provider to give you one! Bring this record with you every time you seek medical care.

Make sure your health care provider records all your vaccinations on it.