



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Lott FIRST NAME: Lindsay 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.

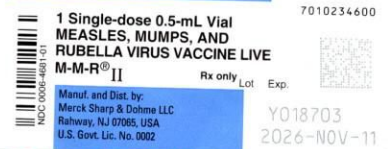
DATE OF MEASLES (RUBEOLA) TITER: 11/5/25 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)
DATE OF MUMPS TITER: 11/5/25 POSITIVE? ☐ (≥ 1.1 AI) NEGATIVE? ☒ (≤ 0.8 AI) (please identify results with a ☒)
DATE OF RUBELLA (MEASLES) TITER: 11/5/25 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a ☒)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Hayley Guthrie, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023

#1. OT arm sub Q



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: <u>12/15/25</u>	DOSE #2	MEASLES (RUBEOLA)	DATE: _____
DOSE #1	MUMPS	DATE: <u>12/15/25</u>	DOSE #2	MUMPS	DATE: _____
DOSE #1	RUBELLA (MEASLES)	DATE: <u>12/15/25</u>	DOSE #2	RUBELLA (MEASLES)	DATE: _____

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Breana Till, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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STUDENT HEALTH CENTER
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P.O. BOX 244023
MONTGOMERY, AL 36124-4023

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: Lott

FIRST NAME: Lindsay

TSCC ID #: _____

HAVE YOU COMPLETED A SERIES OF HEPATITIS B IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

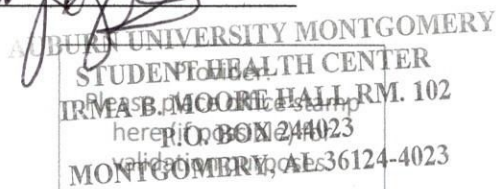
HEPATITIS B TITER - TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER.

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: 11/5/25 POSITIVE? _____ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? ☒ (anti-HBs ≤ 10 mIU/mL) (please identify results with a ☒)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Hayley Guthrie, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

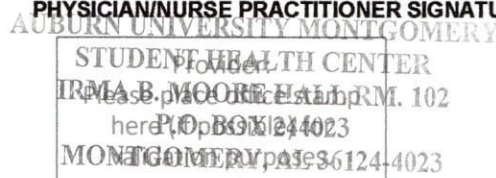


**IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!
IF YOUR RESULTS ARE NEGATIVE - COMPLETE STEP 2 BELOW.**

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: 11/12/2025

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____



NDC 58180-821-43

**Hepatitis B
Vaccine
(Recombinant)
ENGRIX-B**

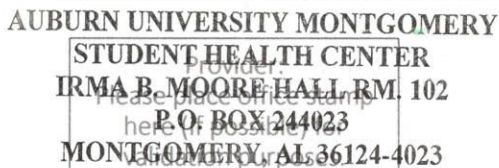
20 mcg/mL

Mfd. by
GlaxoSmithKline
Biologicals

495702

2ND VACCINATION DATE: 12/15/2025
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____



NDC 58180-821-43

**Hepatitis B
Vaccine
(Recombinant)
ENGRIX-B**

20 mcg/mL

Mfd. by
GlaxoSmithKline
Biologicals

495702

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 ☒)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



12/4/02

VARICELLA (CHICKEN POX) IMMUNIZATIONLAST NAME: LottFIRST NAME: Lindsay

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: 11/5/25 POSITIVE? _____ (≥ 1.1 AI) NEGATIVE? ☒ (≤ 0.8 AI) (please identify results with a ✓)PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Hayley Guthrie, CRNPPHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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 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: Lott

FIRST NAME: Lindsay

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: 4/4/03

DATE OF MOST RECENT BOOSTER: 11/9/2025

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT)

Hayley Guthrie

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

Provider:
AUBURN UNIVERSITY MONTGOMERY
Please place office
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
validation, Box 24023
MONTGOMERY, AL 36124-4023

LOT: PD324
EXP: 08/30/27

NDC 58160-842-43

Tetanus Toxoid,
Reduced Diphtheria
Toxoid and Acellular Pertussis
Vaccine, Adsorbed
BOOSTRIX

0.5 mL

Mfd by
GlaxoSmithKline
Biologicals



496018

Left De Huid, 1m
vis 11/5/25

Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME Lindsay Lott
DATE OF BIRTH 12, 4, 2002
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 Lindsay Lott DATE 11/5/2025
FORM REVIEWED BY MSU RN DATE 11/5/2025

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.

6 changes-11/12/25 Lindsay Lott
Daedra Mangotte



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

www.immunize.org/catg.d/p4065.pdf
Item #P4065 (11/6/2023)



6 changes 12/15/2025 Lindsay Lott
MSU RN

hwd
vaccine
11/12/25