



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Mallory

FIRST NAME: Juliauna

TSCC ID #: 02585348

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: _____ POSITIVE? _____ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)
DATE OF MUMPS TITER: _____ POSITIVE? _____ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)
DATE OF RUBELLA (MEASLES) TITER: _____ POSITIVE? _____ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.7 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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

*Not performed
at our site.*

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>12/8/25</u>	DOSE # 2	MEASLES (RUBEOLA)	DATE: _____
DOSE # 1	MUMPS	DATE: <u>12/8/25</u>	DOSE # 2	MUMPS	DATE: _____
DOSE # 1	RUBELLA (MEASLES)	DATE: <u>12/8/25</u>	DOSE # 2	RUBELLA (MEASLES)	DATE: _____

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Haley Guthrie, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
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 _____

AUM Student Health Services

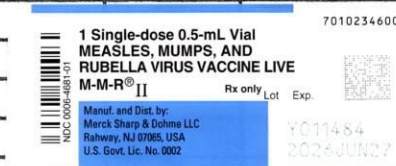
Immunization Record

Patient Name: Juliana Mallory

Birthdate: 9/13/1996

Allergies/Medical Alert: NKA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR	12/8/25	RT arm Sub Q				1/31/25	MS
HEP A							
HEP B							
Other							



Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials

Initials	Signature	Initials	Signature
MS	MS [Signature]		

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STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME Juliana Mallory
DATE OF BIRTH 09.03.1996
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 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

Juliana Mallory

DATE

FORM REVIEWED BY

MB RN

DATE

12/6/2025

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.



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

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



my vaccine