

# AUM Student Health Services

## Immunization Record

Patient Name: Lorraine Martin

Birthdate: 02/11/1956

Allergies/Medical Alert: NKA

| Immunization | Date    | Site         | Dose | MFR | Comments | V.I. S. | Initials |
|--------------|---------|--------------|------|-----|----------|---------|----------|
| Tdap         |         |              |      |     |          |         |          |
| Td Booster   |         |              |      |     |          |         |          |
| MMR          | 2/18/12 | RTU<br>Sub Q |      |     |          | 1/5/12  | MS       |
| HEP A        |         |              |      |     |          |         |          |
| HEP B        |         |              |      |     |          |         |          |
| Other        |         |              |      |     |          |         |          |

1 Single-dose 0.5-mL Vial  
MEASLES, MUMPS, AND  
RUBELLA VIRUS VACCINE LIVE  
M-M-R® II  
Rx only Lot: Exp:  
Manuf. and Dist. by:  
Merck Sharp & Dohme LLC  
Rahway, NJ 07065, USA  
U.S. Govt. Lic. No. 0002

7010234600

Y018703  
2026-NOV-11

| Tuberculin Testing<br>PPD (MANTOUX)<br>0.1 ml ID | Date Given: | Date Read: | Results: | MFR | LOT# | Comments | Initials |
|--------------------------------------------------|-------------|------------|----------|-----|------|----------|----------|
|                                                  |             |            |          |     |      |          |          |
|                                                  |             |            |          |     |      |          |          |
|                                                  |             |            |          |     |      |          |          |
|                                                  |             |            |          |     |      |          |          |

| Initials | Signature | Initials | Signature |
|----------|-----------|----------|-----------|
| MS       | MS        |          |           |
|          |           |          |           |
|          |           |          |           |

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

STAMP ABOVE

# Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME Lorraine C. Martin  
DATE OF BIRTH 2 / 11 / 56  
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?                                                                                                                                                                                                                                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have allergies to medications, food, a vaccine component, or latex?                                                                                                                                                                                      | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction after receiving a vaccine?                                                                                                                                                                                                 | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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?            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?                                                                                                                                                                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a parent, brother, or sister with an immune system problem?                                                                                                                                                                                         | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had a seizure or a brain or other nervous system problem?                                                                                                                                                                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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?                                                    | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?                                                                                                                                                       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you pregnant?                                                                                                                                                                                                                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you received any vaccinations in the past 4 weeks?                                                                                                                                                                                                        | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 13. Have you ever felt dizzy or faint before, during, or after a shot?                                                                                                                                                                                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 14. Are you anxious about getting a shot today?                                                                                                                                                                                                                    | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

FORM COMPLETED BY Lorraine Martin

DATE 2-18-2026

FORM REVIEWED BY MB

DATE 2/18/2026

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](http://www.immunize.org) / FOR THE PUBLIC [www.vaccineinformation.org](http://www.vaccineinformation.org)

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

