

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Minger Wang
DATE OF BIRTH 2/1/1997
month day year

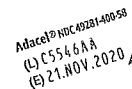
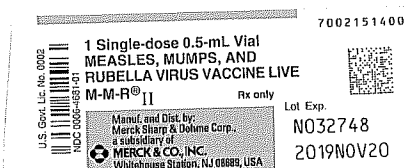
For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare 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 Minger Wang DATE 8/10/18
FORM REVIEWED BY _____ DATE _____

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.



Technical content reviewed by the Centers for Disease Control and Prevention

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

www.immunize.org/catg.d/p4065.pdf • Item #P4065 (4/18)

MEDICAL INFORMATION FORM
AUBURN UNIVERSITY
(CONFIDENTIAL)

RECEIVED
SEP 05 2013

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: aumcmrecords@eamc.org

473900

GENERAL INFORMATION

Name: WANG MING ER Social Security # 903930506
Last First Middle AU User ID/GID
Home Address: _____ Student's Cell Phone: (____) - _____
City: _____ State: _____ Zip: _____
Date of Birth: 2/1/97 Sex (circle one) M Auburn Email Address: MZW0002
Emergency Contact - Name: _____ 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: 08/16/16 Date results read (must be no earlier than 48 hours and no later than 72 hours): 08/18/16

Results of PPD (MUST BE DOCUMENTED IN MM - NO EXCEPTIONS!) 0 mm PLEASE, DO NOT WRITE "Negative" Negative

Documentation / Evaluation

M.D. Printed Name

&

M.D. Signature

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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 08/16/16 Type (circle): MMR MR M

M.D. Printed Name

&

M.D. Signature

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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