

Auburn University Montgomery

Student Health Services

P. O. Box 244023

7461 East Drive

Montgomery, Al 36124

Office (334) 244-3281, Fax (334) 244-3396

Release of Records

This is to verify that a copy of the following records and/or lab results were given to

Cao, Ziwei on 06-13-18
Print Patient's Name Date

Description of record(s) copied: Immunization Records

Ziwei Cao
Patient's Signature
6/13/2018
Date

Immunization Form

To ensure the health and safety of our campus, immunizations against communicable diseases is extremely important. Vaccination against Measles, Mumps, Rubella (MMR), Tetanus, Diphtheria and Pertussis, and proof of negative Tuberculosis is required of all students entering Auburn Montgomery. This form must be completed and is the preferred document for proof of immunizations and TB testing.

Complete and Return to: Student Health Center
Attn: Immunizations
PO Box 244023
Montgomery, AL 36124
(334) 244-3281 Fax (334) 244-3396

Name Cao Ziwei Student Number _____
Last First Middle
Address _____
Street City State Zip Code
Phone Number 334-372-8595 Cell Phone Number _____ E-mail Address _____ Date of Birth 10/24/97

REQUIRED IMMUNIZATIONS

☒ Tuberculosis Screening (within 6 months prior to semester student is to begin at AUM.)
Date Given _____ (Date of reading, within 48 to 72 hours of date given) TB skin test (PPD) 04/24/18
Results: Positive _____ mm Negative 0.0 mm
If positive, you must attach a radiology report from chest X-ray and documentation of treatment.

☒ Tetanus, Diphtheria, Pertussis Vaccine (preferred). Students without previous documentation of a TDaP vaccine should have one dose prior to entrance based on current guidelines. Other students should be current to maintain their status throughout their entire academic career.
Date of TDaP vaccine: _____ / _____ / _____
or Td 03/20/18 (within the last 5 years)

☒ Measles, Mumps, Rubella (MMR)
Auburn Montgomery University requires that all students born after 1956 must have had 2 doses of a measles containing vaccine (MMR) prior to registration. One dose must have been after 1980. Lab antibody titers (IgG) for Measles, Mumps and Rubella are acceptable. Please attach documentation to the back of the form.

Date of First Dose 10/20/14 Date of Second Dose 04/23/18

OPTIONAL IMMUNIZATIONS (These immunizations are not required by the university but are recommended by the American College Health Association.)

Hepatitis B: _____ / _____ / _____
1st 2nd 3rd

Varicella (Chickenpox) Vaccine: _____ / _____ / _____
1st 2nd

Meningococcal (meningitis) Vaccine: _____ / _____ / _____ (MCV4 preferred)
1st 2nd

I certify that the above dates and vaccinations are true.

[Signature]
Signature of License Health Care professional Date 6/13/18

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023
(Approved 8/2012)

STATE OF ALABAMA CERTIFICATE OF IMMUNIZATION

EXPIRATION DATE REQUIRED
(Date next vaccine is due)

Month Day Year

ZIWEI CAO

Name of Child

10/26/97

Date of Birth

Parent or Guardian

Diphtheria, Tetanus, and Pertussis Vaccine (Circle vaccine given.) A medical exemption (see reverse side) is required for children less than 7 years of age who are not given pertussis vaccine.

Tetanus &

03/20/2018

Polio Vaccine (Circle vaccine given.)

Measles, Mumps, Rubella (Circle vaccine given.)

MMR

MMR

10/20/2016

04/23/2018

Mo/Day/Year

Mo/Day/Year

Haemophilus influenzae Type b (Required for Day Care and Head Start only. Please record for historical information.)

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Varicella Vaccine (Required for Day Care and Head Start September 2000. Required for Kindergarten entry Fall of 2001 and for a grade higher each successive year.)

In lieu of Varicella Vaccine

History of Chickenpox

Mo/Day/Year

Positive Varicella

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Not required for school attendance. Please record for historical information. Do not expire this certificate for these vaccines.

Hepatitis B Vaccine

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Pneumococcal Conjugate Vaccine

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Other: Specify Vaccine (not to include TB skin test)

Vaccine _____ Date _____ Vaccine _____ Date _____ Vaccine _____ Date _____

M. Cao, CRNP
Authorized Medical Signature

6/13/18
Date

Name of Clinic

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME ZINEI CAO
DATE OF BIRTH 01/26/1967
month day year

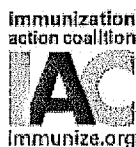
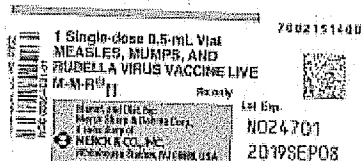
For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare 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 ZINEI CAO DATE 4/23/2018
FORM REVIEWED BY [Signature] DATE 4/23/18

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.



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

Technical content reviewed by the Centers for Disease Control and Prevention

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

Emergency Department Medication Reconciliation
Troy Regional Medical Center

PATIENT: CAO, ZIWEI

MRN: 0161994

Acct. No: 20321085

Wt: 115 kg(254 lb) S Ht: 185 cm(73 in)

PROVIDER: THEODORE MORGAN, MD

Date of Service: 3/19/2018

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Allergy History

Patient or patient family denies any allergies

Resume all home medications unless otherwise instructed

Reported Home Medications		☒ Per Patient	☐ Per Med Record	☐ Per Pharmacy
Medication	Dose	Route	Frequency	Last Dosage
				Discontinue & Follow up with Primary MD
None				☐

Medications Administered in Emergency Dept			
Medication	Time Given	Comment	RN Initial
TETANUS/DIPHTHERIA (td) VACCINE 0.5ML GIVEN: 0.5 ml - R Deltoid IM	03/20/2018 02:05		

RN Signatures		
Initials	Initials	Initials

New Medication Orders					
Medication	Dose	Unit	Frequency	Comment	RX Given
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐

*Please tell
Kelly or Judy
this one is
clear.*

Because your home medications were prescribed by your personal doctor (PCP), the decision regarding whether these medications are appropriate for you should be made by your PCP, not the Emergency Department physician/PA. Unless otherwise specified above, continue your home medications.

Nurse Signature: _____ Date: ____/____/____ Time: ____:____