

Immunization Record

Patient Name:

Tristen Holley

Birthdate:

12/16/2001

Allergies/Medical Alert:

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap	7/26/24	R Deltoid		LOT: 9935H EXP: 07/03/26		8/16/21	JNB
		1m		NDC 58160-842-43			
Td Booster				Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX	0.5 mL		
MMR				Mfg. by GlaxoSmithKline Biologicals	496018		
HEP A							
HEP B							
Other							

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	7/26/24	7/29/24	Imm Negative	Sanofi	3CA18C1	exp 4/27 (RFA)	JNB

Initials	Signature	Initials	Signature

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

PATIENT NAME Tristen Holley
DATE OF BIRTH 12 / 16 / 2001
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 Tristen Holley DATE 7/26/24
FORM REVIEWED BY MBR DATE 7/26/24

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.



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Tristen Holley

Date of Birth: 12/14/2001

Student Number: _____

Please mark "yes" or "no" to the following questions.

YES NO

1. Do you have a cough that has lasted longer than 3 weeks?		✓
2. Have you coughed up blood or mucus?		✓
3. Have you had fever, chills, or night sweats?		✓
4. Have you had unintentional weight loss?		✓
5. Have you been feeling very tired?		✓
6. Have you lost your appetite?		✓
7. Have you ever had a positive TB skin test result or Positive interferon gamma release assay (IGRA) result? If so, when?		✓
8. Have you ever had an abnormal chest x-ray?		✓
9. Have you recently had the mucus coughed up tested for TB?		✓
10. Have you ever been told you had TB or latent TB?		✓
11. Have you ever taken medicine for TB?		✓
12. Have you ever lived with or had close contact with someone who had TB?		✓
13. Do you currently have a rash on either forearm?		✓
14. Are you immunocompromised? (Steroids, chemotherapy, or other?)		✓
15. Have you received a live vaccine in the past 30 days?		✓

All TB skin test and Chest x-rays must be performed in the U.S. to be valid.

I attest the above is true and accurate to the best of my knowledge.

Patient Signature:

Date: 7/26/24

Provider Signature: RN

Date: 7/26/2024

ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: HOLLEY, TRISTEN LAYNE
 DOB: 12-16-2001
 Chart #:
 Date of Service: 02-14-2024

Vaccine Family	Type of Vaccine (no Brand Name)	Date Given (mm/dd/yy)	Age at Adm	Dose (cc/mL)	Route & Site	Mfr.	Lot #	VIS Date	Vaccinator Signature
Tetanus, Diphtheria, (Pertussis) (e.g., Td, Tdap)	DTAP	02/15/02	1 m	0.5					
	DTAP	02/15/02	1 m	0.5					
	DTAP	04/17/02	4 m	0.5					
	DTAP	04/17/02	4 m	0.5					
	DTAP	06/19/02	6 m	0.5					
	DTAP	06/19/02	6 m	0.5					
	DTAP	06/24/03	18 m	0.5					
	DTAP	08/24/03	20 m	0.5					
	DTAP	01/10/07	5 y	0.5					
	DTAP	01/10/07	5 y	0.5					
	TDAP	06/06/13	11 y	1.0	IM RA		C4365AA		
Hepatitis A (e.g., HepA, HepA-HepB)	HEP A	06/06/17	15 y	0.5	IM	MSD	N012324	10/15/2021	
	HEP A	03/02/18	16 y	0.5	IM	MSD	N023953	10/15/2021	OUTSIDE CLINIC
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA- HepB)	HEP B ADOL/PED	01/17/02	1 m	0.5					
	HEP B UNS	02/15/02	1 m	0.5					
	HEP B ADOL/PED	02/25/02	2 m	0.5					
	HEP B ADOL/PED	12/17/02	12 m	0.5					
Human Papillomavirus (e.g., HPV)									
Measles, Mumps, Rubella (MMR, MMRV)	MMR	03/18/03	15 m	0.5					
	MMR	01/10/07	5 y	0.5					
Meningococcal (MCV4, MPSV4)	MCV40 (MENVEO)	06/06/13	11 y	0.5					
	MCV40 (MENVEO)	06/20/18	16 y	0.5	IM LD	SKB	M16131		OUTSIDE CLINIC
Pneumococcal (e.g. PCV, PPV)	PCV7	02/15/02	1 m	0.5					
	PCV7	04/17/02	4 m	0.5					
	PCV7	09/17/02	9 m	0.5					
Polio (e.g., IPV, DTaP-HepB- Hib)	IPV	02/15/02	1 m	0.5					
	IPV	04/17/02	4 m	0.5					
	IPV	12/17/02	12 m	0.5					
	IPV	06/24/03	18 m	0.5					
	IPV	01/10/07	5 y	0.5					
Varicella (Var, MMRV)	VARICELLA	03/18/03	15 m	0.5					
	VARICELLA	01/10/07	5 y	0.5					
Influenza (e.g., TIV, LAIV)	IIV3 SEASONAL	09/12/09	7 y	1.0			U3191AA		
	IIV3 SEASONAL	10/17/09	7 y	1.0			U3191AA		
	IIV3 SEASONAL	01/27/11	9 y	1.0			U3737AA		
Zoster									
Other	HIB (PRP-OMP)	02/15/02	1 m	0.5					
	HIB (PRP-OMP)	04/17/02	4 m	0.5					
	HIB (PRP-OMP)	12/17/02	12 m	0.5					

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PPD	Date	Results	PPD	Date	Results
Mantoux			Mantoux		
Mantoux			Mantoux		
Mantoux			Mantoux		