

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Karen Albritten
DATE OF BIRTH 04/27/1960
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), <u>anemia</u> , or other blood disorder? <i>in the past, not now</i>	☐	☒	☐
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 Karen Albritten DATE 6/19/18
FORM REVIEWED BY [Signature] DATE 6/19/18

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.



Hepatitis A and B

Date: 11/8/18

Dear Mrs. Albritten:

Your final Hepatitis A and B vaccine is now due on, Nov 19, 2018

Please call the Nursing Care Center for an appointment as soon as possible at 244-3281.

Thank you for allowing us to participate in the protection of your good health.

Sincerely,

Amy Morris, BSN RN-BC



Hepatitis A and B Reminder

Date: 6/12/18

Dear Mrs. Albritten:

Your second Hepatitis A and B (Twinrix) vaccine is ~~due on~~ now due.
Please call the Student Health Center at Auburn
Montgomery for an appointment as soon as possible at 244-3281, to
continue receiving your immunization as scheduled.

In order to stay within the recommended schedule, you should receive your
next dose by June 22, 2018.

Thank you for allowing us to participate in the protection of your good
health.

Sincerely,

Amy Morris, RN-BC 

Amy Morris, RN-BC
AUM-Nursing Care Center

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

AUBURN MONTGOMERY
STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023
(334) 244-3281

Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

Darlene Pierce, C.R.N.P.
Lic. #1-134315
RX: 3692

Mariuz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Name Karen Albritten Date 5/2/18

Address _____

Rx

Malarone 250/100mg

Disp: 19

Sig: Take one pill a day. Begin 2 days before
departure, continue through stay and
for 7 days after return.

L. Stewart

M.D. or C.R.N.P.

Product Selection Permitted

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Dispense As Written

M.D. or C.R.N.P.

ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: _____

Name: Karen Albritten

Date of Birth: 9/27/60 Record #: _____

Allergies: _____ Reactions: _____

History of Chickenpox? YES or NO If yes, date if known: _____

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf Abb [†]	Lot	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr						
Td					Td			EXP: 95KG9 10/29/20		0.5cc		IM	
Td					Td			NDC 58160-815-43		0.5cc		IM	
Td					Td			Hepatitis A & Hepatitis B (Recombinant) Vaccine		0.5cc		IM	
Td					Td			TWINRIX®		0.5cc		IM	
Tdap					Tdap			Mfd. by GlaxoSmithKline Biologicals		0.5cc		IM	
Hep B + Hep A	5	2	18		Hep A Hep B	7	16	LOT: 95KG9 EXP: 10/29/20		1.0	LD	IM	AM
Hep B + Hep A	6	19	18		Hep A Hep B	7	16			1.0	LD	IM	AM
Hep B					Hep B			NDC 58160-815-43				IM	
Hep B (booster if needed)					Hep B			Hepatitis A & Hepatitis B (Recombinant) Vaccine				IM	
MMR Rubella Rubeola					MMR			TWINRIX®		0.5cc		SQ	
MMR Rubella Rubeola					MMR			Mfd. by GlaxoSmithKline Biologicals		0.5cc		SQ	
Varicella					Var			474193		0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV					0.5cc		IM	
Hepatitis A					Hep A							IM	
Hepatitis A					Hep A							IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
MCV4					Mening							IM	
MPSV4					Mening							SQ	

* Manufacturers: M= Merck; S = Sanofi Pasteur; W = Wyeth; G = GlaxoSmithKline

** Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm, LD = Left Deltoid, RD = Right Deltoid

*** VIS Language given, if not English: _____

Typhoid 5/2/18 @ Del + 0.5cc SP(N1H341M) *Sybil RN*