

ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: AUM-SHS

Name: Sam Davidson

Date of Birth: 3/9/78 Record #: _____

Allergies: NKMA Reactions: _____

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

Vaccine	Date Admin			Age at the time	VIS Form Given			Manufacturer Abbrev	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr					
Td					Td			NDC 58160-821-43	0.5cc		IM	
Td					Td			Hepatitis B Vaccine (Recombinant) ENGERIX-B®	0.5cc		IM	
Td					Td			20 mcg/mL	0.5cc		IM	
Td					Td			Mfd. by GlaxoSmithKline Biologicals	0.5cc		IM	
Tdap					Tdap				0.5cc		IM	
Hep B	5	2	18		Hep B	7	16	LOT: 94S22 EXP: 09/04/20	1.0	LD	IM	AM
Hep B	7	3	18		Hep B	7	16	NDC 58160-821-43	1.0	LD	IM	AM
Hep B	11	30	18		Hep B	7	16	Hepatitis B Vaccine (Recombinant) ENGERIX-B®	1.0	LD	IM	AM
Hep B (booster if needed)					Hep B			20 mcg/mL			IM	94S22 Lot
MMR Rubella Rubeola					MMR			Mfd. by GlaxoSmithKline Biologicals	0.5cc		SQ	
MMR Rubella Rubeola					MMR			474430	0.5cc		SQ	
Varicella					Var				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: _____

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Sam Davidson
DATE OF BIRTH 3 / 9 / 18
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 Sam Davidson DATE 7-3-18
FORM REVIEWED BY [Signature] DATE 7/3/18

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.

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 4-23-18 Are you an AUM student? YES ☐ NO ☒ Student ID # _____

Name: Sam Davidson

Social Security Number: 418-21-2821 Birth Date: 3-9-78

Local Phone Number: 334 207 5255 Alternate Number: _____

Local Address: 9555 Gunnison Dr Box Number: _____

City: Pike Road State: AL Zip Code: 36064

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status (Please Circle): Single ☐ Married ☒ Divorced ☐ Widowed ☐ Other _____

Sex (Please Circle): Male ☒ Female ☐

Primary Physician: _____ City: _____ Phone #: _____

Patient's Employer: ~~Cater~~ Pike Road Fire Work #: 334 271 1048

Parent's or ☒ Spouse's Name (Circle which) Leigh Phone #: 334-558-1661

Parent's or Spouse's Employer: _____ Work #: _____

Emergency Contact: Toni Davidson Relationship: Mother Phone #: 334 697 6727

How did you hear about the Clinic? Friend ☐ Faculty/Staff ☐ Orientation ☐ Other ☒ _____

INSURANCE INFORMATION

Do you have health insurance? YES NO

If yes, please give your card to the receptionist in order for a copy to be made for your chart.

Insurance Company _____ Name on Card _____

Policy Number _____ Group Number _____

Insurance Company Address _____

Patient Bill of Rights

AUM Nursing Care Center (AUM NCC) exists primarily for the purpose of providing high quality care that meets or exceeds accepted standards for care. AUM NCC believes that each client is worthy of respect and understanding and has certain rights and responsibilities related to the care he/she receives. In accordance with this philosophy, AUM NCC wishes to advise you of the following rights and responsibilities and to assist you in understanding and exercising these rights.

As a client of AUM NCC, you have the right to:

1. Be treated with dignity, courtesy, and respect.
2. Obtain from caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. Know the identity of all caregivers involved in their care, as well as when those involved are students or trainees.
4. Know the immediate and long-term financial implications of treatment choices, insofar as they are known.
5. Make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and AUM NCC policy and to be informed of the medical consequences of the action. In case of refusal, the patient is entitled to other appropriate care and services or to be referred to another health care facility.
6. Receive competent, individualized quality services from AUM NCC regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, or any other category protected by law.
7. Expect confidentiality of all clinical records and access to your records on request. Information will not be released to anyone without your written consent or unless required by law.
8. Have family or guardian exercise these rights on your behalf if you are unable to do so yourself.
9. Voice grievances about care which is or is not provided, recommend policy/service changes, and make complaints without fear of reprisal or unreasonable interruption of care.

I also understand I have a responsibility to:

1. Provide accurate and complete information to AUM NCC regarding medical history and current condition and medications, and to promptly inform AUM NCC of any changes in this information.
2. Agree to accept all caregivers regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, being a qualified veteran of the Vietnam era, or any other category protected by law.
3. Participate in planning, evaluation and revising my plan of care to the degree that I am able to do so and to take responsibility for my actions and for the impact that those actions have on my health and recovery.
4. Adhere to the plan of care which I have participated in developing.
5. Treat AUM NCC staff with respect, courtesy, and consideration.

I have read and understand the above Patient Bill of Rights and agree to the contents thereof.

Patient Signature: _____

Date: _____

SERVICES CONSENT FORM

X NAME: Sam Davidson
DATE OF BIRTH: 3-9-78

I AM REQUESTING CARE FOR MYSELF OR MY ABOVE NAMED DEPENDENT AND
GIVE MY CONSENT FOR TREATMENT. I AM RESPONSIBLE FOR ALL BILLS
INCURRED AT THE NURSING CARE CENTER.

X SIGNATURE: Sam Davidson
DATE: 4-23-18

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
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AUM NURSING CARE CENTER
ADOLESCENT/ADULT HEALTH HISTORY

Date _____

Name Sam Davidson

1. What is the reason for your visit today? Hepatitis B Vaccination
2. Is there anything about you and your health that we need to know? _____
3. List medicine, drugs, or food you are allergic to: _____
4. List any medicines or drugs you take: _____

5. Have YOU or anyone in your family had any of the following: (circle)

heart disease
high blood pressure
stroke

diabetes/sugar
blood problem or disease
cancer

tuberculosis
birth defects
mental retardation

nerve or mental problems
asthma
died before age 50
other "family" disease

6. Have you ever been in the hospital? ✓ Why? Pneumonia
7. Have you ever had surgery? no Why? _____
8. Have you ever had a serious accident? _____
9. Have you had serious or recent problems with:

ears or throat NO YES
allergies NO YES
lung infections NO YES

cough NO YES
thyroid NO YES
skin problems NO YES

kidneys NO YES
weight loss NO YES
ulcers NO YES

gallbladder NO YES
liver NO YES
depression NO YES
headaches NO YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
12. Have you ever smoked cigarettes or used smokeless tobacco? NO YES
- If yes, are you an: Ex-smoker Smoking now? _____ Do you smoke (less) (more) than a pack a day? _____
- How much smokeless tobacco do you use a day? _____
13. How often do you drink beer, wine, wine coolers, or liquor? _____
- Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week
- If you drink beer, wine, wine coolers, or liquor, do you have: (less) (more) than 5 drinks a day?

14. Have you ever used marijuana, cocaine, crack or other drugs? NO YES
15. Have you ever used I.V. drugs? NO YES
16. Have you ever had a blood transfusion? NO YES
17. Do you have any tattoos? NO YES
18. Have you ever been treated for a venereal disease? NO YES
19. Have you had more than one sex partner in the past 5 years? NO YES
20. Have you ever had sex with a member of your own sex? NO YES
21. Have you had or been around anyone with hepatitis? NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? _____ Date of your last period? _____
- How often do you have your periods? _____ Are they regular? _____
- How many days do they last? _____
- Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
- Do you check them regularly? YES NO
- C. How many times have you ever been pregnant? _____ How many children are living? _____
- Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES
- Were any of your children premature? NO YES
- How old were you when your first child was born? _____
- D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES;
- diaphragm? NO YES
- E. Did you have problems with any of these methods? NO YES
- F. Have you ever had an abnormal PAP smear? NO YES

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	yes	no	don't know
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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?	☐	☒	☐
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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?	☐	☒	☐
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FORM COMPLETED BY Sam Davidson DATE 5-2-18
FORM REVIEWED BY [Signature] DATE 5/2/18

Did you bring your immunization record card with you? yes ☐ no ☐

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Hepatitis B Reminder

Date: 11/8/18

Dear Mr. Davidson

Your third Hepatitis B vaccination is due ~~on~~ now.

It is important that you continue your series within the recommended schedule to obtain the maximum effect from your vaccination.

In order to achieve maximum benefits, you should receive your vaccine no later than

Dec 1, 2018

If you have received this immunization elsewhere, please notify us, so that we will take you off our reminder list.

If you wish to continue this immunization with the AUM Student Health Center, please call the clinic to schedule an appointment as soon as possible at 244-3281 to continue receiving your immunization as scheduled.

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

Sincerely,

Amy Morris

Amy Morris, BSN, RN-BC

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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

Sam Davidson

DATE

11-30-18

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.