

AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 5/17/18 Name Kenley Obas

1. What is the reason for your visit today Plan to travel International to Cape Town S.A.
2. List allergies you have to medicines, foods or iodine: _____
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): _____
4. Have you had any of the following: (circle if this applies to you);
Heart disease _____
Kidney disease _____
Stomach/Gastrointestinal disease _____
Diabetes/sugar _____
5. Are you immunocompromised? (Is there a problem with your immune system) Yes _____ No _____
Thymus disorder (Myasthenia gravis, thymoma, thymectomy) _____
Spleen removed _____
Transplant recipient _____
Cirrhosis of the liver _____
Cancer _____
HIV _____
6. How often do you drink beer, wine, wine cooler, or liquor? (Please circle)
Never / Rarely / 1-2 times a week / 3-4 times a week / 5 or more times a week
7. Where are you going on your trip? Cape Town, South Africa
8. How long is your trip? Months _____ Days 7 days
9. When are you leaving on your trip? June 6

FOR FEMALES ONLY

- A. Date of your last period? _____ Have you had a hysterectomy? YES _____ NO _____
- B. Are you currently pregnant? YES _____ NO _____
What is your due date? _____
- C. Do you plan to become pregnant in the next 3 months? YES _____ NO _____
- D. Are you breastfeeding? YES _____ NO _____

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Kenley Obas
DATE OF BIRTH 08/18/71
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 Kenley Obas DATE 8/5/18
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.

Clinic Identification Stamp

AUBURN UNIVERSITY MONTGOMERY
NURSING CARE CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023

PHALCON LABEL

Name Kenley Obas
Date of Service 6/27/08
CHR # _____

PPD	DATE	RESULTS	PPD	DATE	RESULTS	PPD	DATE	RESULTS
MANTOUX			MANTOUX			MANTOUX		
PPD	DATE	RESULTS	PPD	DATE	RESULTS	PPD	DATE	RESULTS
MANTOUX			MANTOUX			MANTOUX		

Vaccine	Date Admin.			Age at the Time	VIS Type & Date	Manufacturer & Lot Number	Administration:	Q	Professional Signature
	Mo	Day	Yr				Amt. Site & Route		
MMRV							0.5cc SQ LA RA		
MMRV							0.5cc SQ LA RA		
MMR							0.5cc SQ LA RA		
MMR							0.5cc SQ LA RA		
Varicella							Vial SQ LA RA		
Varicella							Vial SQ LA RA		
Tdap Td	6	27	08	36	7/06	Adacel [®] Adolescent/Adult (I) C2774AA	0.5ccIM LA (RA)		Lyon Lyon
Tdap Td	5	7	18		2/15	Adacel [®] NDC 49281-409-51 (L) C5467CA (E) 20 JUN 2020	0.5ccIM LA (RA)		
Tdap Td							0.5ccIM LA RA		
Meningococcal Conjugate (MCV4, MPSV-4)							0.5ccIM LA RA		
Pneumococcal 23-valent (PPV 23)							0.5ccIM LA RA SQ		
Pneumococcal 23-valent (PPV 23)						HAVERIX [®] Hepatitis A Vaccine	0.5ccIM LA RA SQ		
Hepatitis A	6	27	08	36	3/06	LOT AHAVB224AA EXP. 06/26/10 HAVERIX [®] Hepatitis A Vaccine	0.5cc LA (RA) 1cc IM LT RT		Lyon Lyon
Hepatitis A	2	17	11		3/06	LOT: AHAVB459AA EXP: 03/04/13	0.5cc LA (RA) 1cc IM LT RT		
Influenza							0.25ccIM LA RA 0.5ccIM LT RT		
Influenza							0.25ccIM LA RA 0.5ccIM LT RT		
Rotavirus							Oral/PO		
Rotavirus							Oral/PO		
Rotavirus							Oral/PO		
Typhoid	3	2	11		5/4	(R) Delta 0.5cc IM SP E1288-1			Lyon

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

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

Name Kenley Obas Date 5/7/18
Address _____

R

Vivotif
Disp: 4
Sig: Take as directed.

[Signature]
Product Selection Permitted

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

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Dispense As Written

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

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

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Lic. #1-039092
Rx: 0703

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

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

Name Kenley Obas Date 5/7/18
Address _____

R

Malarone 250/100mg
Disp: 16
Sig: Take one pill a day. Begin 2 days before
departure, continue through stay and
for 7 days after return.

[Signature]
Product Selection Permitted

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

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Dispense As Written

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

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

Date _____

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1171

AUE J 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

COT-V17-CVRS RV (03-07)

Stacey E. White, C.R.N.P.
Lic. #1-077155
RX: 1501

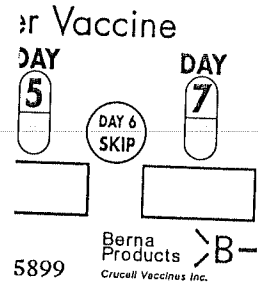
Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

room Mirror

Name Kenley Obas Date 2/17/11

Address _____

Rx Vivotif
Disp: 4 doses
sig: take as directed



Label all prescriptions

Product Selection Permitted

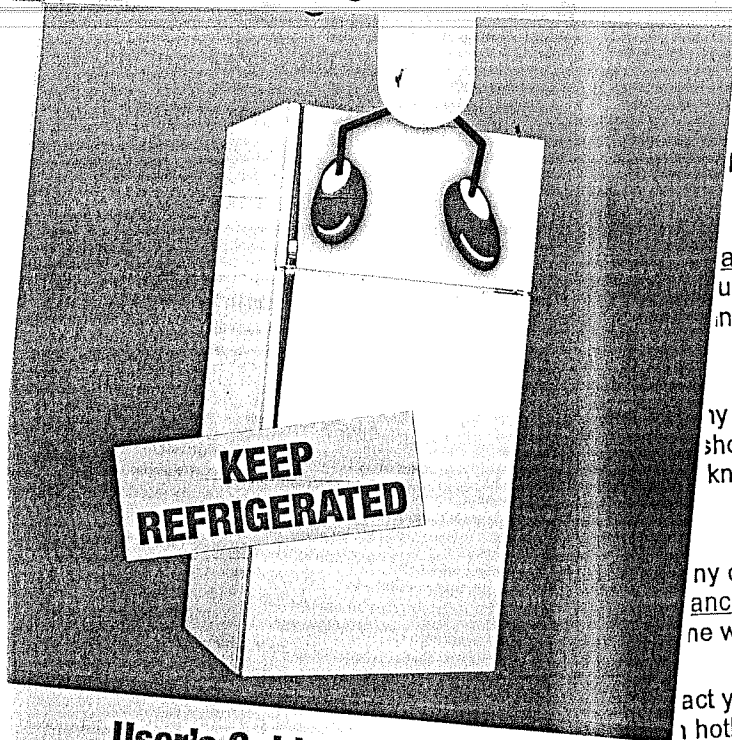
M.D. or C.R.N.P.

Storage

Refill: 1 2 3 5 PRN NR

Dispense As Written

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



Directed, usually one capsule is taken every other day for 4 weeks. Swallow capsule as directed with a warm drink one hour before a meal. Do not take with hot liquid. Replace any broken capsules. Your course of treatment should be completed.

Headache or mild fever may occur. If these symptoms continue or if you notice other effects not listed above, consult your doctor if the following effects occur: breathing or swallowing difficulties and severe tiredness. If you notice other effects not listed above, consult your doctor.

Avoid use if you have any of the following conditions: illness, infection, allergies, or if you are pregnant. Should be used during pregnancy only if clearly needed. Discuss with your doctor if this medication appears in breast milk. Consult your doctor.

Do not take any over-the-counter or prescription medication you may take, including cancer drugs, immunosuppressants, sulfa drugs, antibiotics, or other drugs, without doctor or pharmacist approval.

Contact your local poison control center or emergency room immediately. In the U.S., call the toll-free hotline at 1-800-222-1222. Canadian residents should call their local poison control center.

Not effective in preventing typhoid fever, depending partly on the degree of exposure to avoid contact or ingestion of potentially contaminated food or water.

MISSED DOSE: If you miss a dose, take it as soon as remembered; do not take it if it is near the time for the next dose, instead, skip the missed dose and resume your usual dosing schedule. If you miss more than one dose, contact your doctor to establish a new dosing schedule. Do not "double-up" the dose to catch up.

STORAGE: Store capsules under refrigeration at all times as directed. Keep away from heat and light. Do not store in the bathroom.

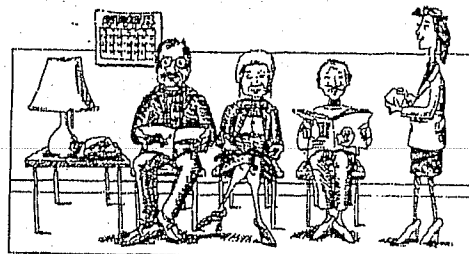
Patient name:

Kenley Obas

Date of birth:

3/2/11
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



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, or any vaccine? <u>staph infections</u>	☒	☒	☐
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, AIDS, or any other immune system problem?	☐	☒	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure, 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:

Kenley Obas

Date:

3/2/11

Form reviewed by:

[Signature]

Date:

3/2/11

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, April 2009.

www.immunize.org/catg.d/p4065.pdf • Item #E4065 (4/09)

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org



Auburn University Montgomery

Student Health Services

Hepatitis A

Date: 1/6/09

Dear Mr. Obas:

Your final Hepatitis A was due on 12/29/08.

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,

A handwritten signature in cursive script, appearing to read 'Amy Morris'.

Amy Morris, B.S.N., RN, BC



Auburn University Montgomery

Student Health Services

Hepatitis A

Date: 12/1/08

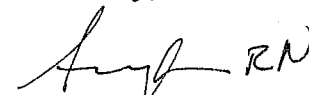
Dear Mr. Obas:

Your final Hepatitis A is due on 12/29/08.

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.

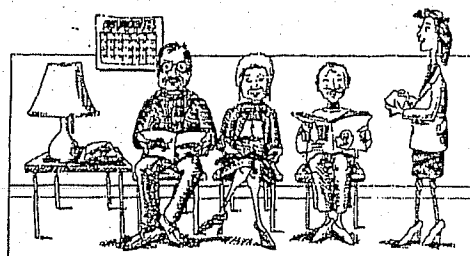
Sincerely,

 RN
Amy Morris, B.S.N., RN, BC

The clinic will be closed for the holidays 12/22/08 - 1/2/09.
Please call for an appointment in January. AM

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



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, or any vaccine?	☐	☒	☐
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, AIDS, or any other immune system problem?	☐	☒	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure, 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: Benley Obas

Date: 2/17/11

Form reviewed by: [Signature]

Date: 2/17/11

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.

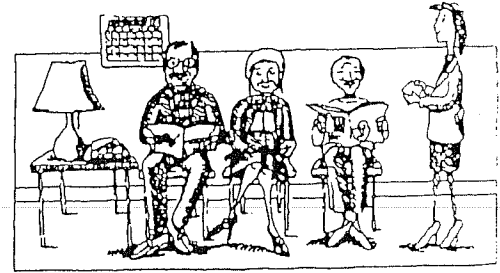
Technical content reviewed by the Centers for Disease Control and Prevention, April 2009.

www.immunize.org/catg.d/p4065.pdf • Item # B4065 (4/09)

Patient name: Kentley Obcis

Date of birth: 8/18/71
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



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, or any vaccine?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☒	☐
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	☐	☒	☐
6. Do you have a seizure, brain, or nerve problem?	☐	☒	☐
7. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	☐	☒	☐
8. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
9. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

Form completed by: Kentley Obcis

Date: 6/26/08

Form reviewed by: [Signature]

Date: 6/27/08

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 record card, ask your healthcare provider to give you one! Bring this record with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

www.immunize.org/catg.d/p4065scr.pdf • Item # P4065 (9/06)