

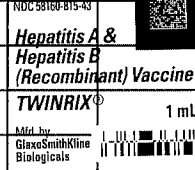
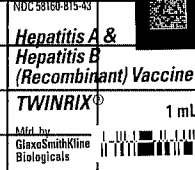
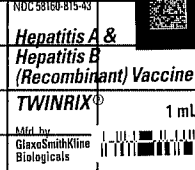
Clinic: _____

Name: Chuck Grant

Date of Birth: 6/14/51 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 AbbV	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr					
Td					Td				0.5cc		IM	
Td					Td				0.5cc		IM	
Td					Td				0.5cc		IM	
Td					Td				0.5cc		IM	
Tdap	5	3	18		Tdap	2	15		0.5cc	LD	IM	Adacel® NDC 49281-400-58 (L) C5467CA (E) 20 JUN 2020 <i>AM</i>
Hep B + Hep A	5	3	18		Hep B	7	16		1.0	RD	IM	
Hep B					Hep B						IM	
Hep B					Hep B						IM	
Hep B (booster if needed)					Hep B						IM	
MMR Rubella Rubeola					MMR				0.5cc		SQ	
MMR Rubella Rubeola					MMR				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: _____

[illegible][illegible]

Enter Test Results for Non-Susceptibility (if any)													
Date			Disease	Results		Notes							
Mo	Day	Yr		Neg	Pos								

[illegible]

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 Chuck Grant

Date 5/3/18

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.

Label all prescriptions

Refill: 1 2 3 5 PRN NR

M. Fuentes, M.D.
Product Selection Permitted

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

Dispense As Written

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