Rebecca M. Sykes Wellness Center
180 Main Street
Andover, MA 01810-4161 USA
978-749-4455, fax 978-749-4452
Email: sykeswellness@andover.edu

Phillips Academy
ANDOVER

TUBERCULOSIS SCREENING FOR HIGH RISK STUDENTS FORM

(To be completed by a licensed healthcare provider for any student with a "yes" answer for TB Risk)

Student name Nguyen Arthur _____ Date of birth 05 / 13 04
(Please print) *Last* *First* *Middle Initial* *Day* *Month* *Year*

Any student with a "YES" answer to any question on previous page of this form must show evidence of further tuberculosis screening. NOTE: BCG (bacille Calmette-Guérin) past immunization *does not* exempt student from further tuberculosis screening. According to the Centers for Disease Control and Prevention, a chest x- ray alone is not sufficient for tuberculosis screening. *A Tuberculin skin test (TST)* ***or*** *an Interferon Gamma Release Assay (IGRA) blood test are required for initial screening.*

PART A: For high-risk students who have **NEVER had a positive TST**

Students require a TST *or* IGRA within 6 months of arrival to Phillips Academy.

Tuberculin Skin Test (TST) Option:	Interferon Gamma Release Assay (IGRA) Option:
Date given 5/13/18 Date read 5/15/18	Date _____
Reading 0 mm	❑Negative ❑Positive* ❑Indeterminate*
Interpretation: ☑Negative ❑Positive*	

- **If TST or IGRA is negative, no further action is required.**
- **If TST or IGRA is positive or indeterminate, please complete PART B.**
- **If student had a positive TST in the past, please complete PART C.**

PART B: For high-risk students who test positive or indeterminate above

Date of chest x-ray _____ Result of chest x-ray: ❑ Normal ❑ Abnormal

Clinical Evaluation: Does the student have signs or symptoms of active pulmonary tuberculosis disease? ❑ Yes ❑No

If YES, check boxes below:

❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production	❑ Coughing up blood (hemoptysis)	❑ Chest pain
❑ Loss of appetite/ Unexplained weight loss	❑ Night sweats	❑ Fever

Describe _____

Treatment: ❑ Yes ❑No Medication/Dose/Dates _____

PART C: For high-risk students with **PAST POSITIVE TST**

If student has had a positive TST test in the past, please provide proof of a negative chest x-ray OR Interferon Gamma Release Assay (IGRA) blood test within 6 months of arrival to Phillips Academy.

Date of positive TST: _____

Date of chest x-ray _____ Result of chest x-ray: ❑ Negative ❑ Positive

-OR-

Date of blood test: _____ Result of blood test: ❑Negative ❑Positive

Treatment: ❑ Yes ❑ No Medication/Dose/Dates: _____

Healthcare provider name (print) David M. Lauren Date 5/13/18

Healthcare provider signature _____

David M. Lauren, D.O.
License # 047449 (CT)
AFC Urgent Care
3000 Summer Street, Stamford, CT 06905
Phone: 203.969.2000 | Fax: 203.504.8733

Parents/Guardians: Please upload completed form to the Medicat Patient Portal:
https://andover.medicatconnect.com

Please contact the Rebecca M. Sykes Wellness Center with questions or concerns at 978-749-4455 or email sykeswellness@andover.edu.
Thank you for your assistance.

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Phillips Academy
ANDOVER

PEDIATRIC TUBERCULOSIS RISK ASSESSMENT FORM

(To be completed by a licensed healthcare provider)

The purpose of this Tuberculosis (TB) Risk Assessment Form is to identify children who may be at increased risk for TB and may require evaluation and testing. **A child with any risk factor described below is a candidate for TB testing, unless there is written documentation of a previous positive Tuberculin skin test (TST) or interferon gamma release assay (IGRA).**

Student name NGUYEN ARTHUR Date of birth 5 / 13 / 2004
(Please print) *Last* *First* *Middle Initial* *Month* *Day* *Year*

Country of residence USA

NOTE: If any questions are answered YES, the Sykes Wellness Center requires that the healthcare provider completes Tuberculosis Students Form on the next page. If the answer to all of the questions is NO, no further TB testing or action is required.

Healthcare provider, please answer the following questions:

1) Has the student ever had a positive TB skin test? ☐ Yes* ☑ No
   - If yes, when? _____

2) Was the child born in Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East? ☑ Yes* ☐ No
   - If yes, in what country was the child born? _____

3) Has the child lived or traveled in Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East for more than one month? ☑ Yes ☐ No

4) In the past 2 years, has the child lived with or spent time with someone who has been sick with TB? ☐ Yes ☑ No

5) Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression? ☐ Yes* ☑ No
   - If yes, please describe _____

Healthcare provider name (please print) DAVID M. LAUREN D.O.

Healthcare provider signature

David M. Lauren, D.O.
License # 047449 (CT)
AFC Urgent Care
3000 Summer Street, Stamford, CT 06905
Phone: 203.969.2000 | Fax: 203.504.8733

Address _____

Telephone _____ Fax _____ Date 5/13/2018

Massachusetts Department of Public Health | Bureau ofInfectious Disease Populations and Infectious DiseasePrevention February 2014 Division of Global

Parents/Guardians: Please upload completed form to the Medicat Patient Portal
https://andover.medicatconnect.com or fax to 978-749-4452.

Please contact the Rebecca M. Sykes Wellness Center with questions or concerns:
978-749-4455 or sykeswellness@andover.edu.

For Rebecca M. Sykes Wellness Center use only.

Rebecca M. Sykes Wellness Center
180 Main Street
Andover, MA 01810-4161 USA
978-749-4455, fax 978-749-4452
Email: sykeswellness@andover.edu

Phillips Academy
ANDOVER

RECORD OF IMMUNIZATION AND PHYSICAL EXAM

(To be completed by a licensed healthcare provider)

Student name Nguyen (Last) Arthur (First) _____ (Middle Initial) Date of birth 05 / 13 / 04 (Month / Day / Year)

(Please print)

A copy of the student's immunization record documenting all required vaccinations with complete dates is acceptable.

Immunizations REQUIRED for all students prior to attending school	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
Diphtheria/Tetanus//Pertussis (DTP or DTap)	10/03/04	12/05/04	12/18/05	3/6/06	
Hepatitis B	5.13.04	8.2.04	5/13/2018		
Meningitis ACWY required (at least 1 within past 5 years)	5/13/2018				
MMR (Measles/Mumps/Rubella) *Important: 2 doses of the combined vaccination of MMR or 2 vaccinations each of Measles, Mumps, or Rubella, are required. Positive Measles, Mumps, or Rubella titers (serology) are accepted with attached labdocumentation of titer result.*	MMR 6.11.05 Or if given separately: Measles _____ Mumps _____ Rubella _____	MMR 12.18.05 Or if given separately: Measles _____ Mumps _____ Rubella _____	Or Dates of Positive Titers: Measle _____ Mumps _____ Rubella _____		
Polio (IPV or OPV)	10.03.04	12.05.04	12.8.05	3/6/06	5/13/2018
Tetanus booster: Tdap (Tetanus/Diphtheria/Pertussis) is recommended. Td (Tetanus/Diphtheria) is acceptable. *must be within past 5 years	Tdap 9/26/15 Td _____				
Varicella (Chicken Pox) *Important: 2 vaccinations are required unless you have a history of the disease documented by a healthcare professional. A positive Varicella titer (serology) is accepted with attached lab documentation of the titer result.*	1/8/06	5/13/2018	Or Date of Disease _____ Or Date of Positive Titer _____		
Immunizations RECOMMENDED					
Hepatitis A	9/26/15	5/13/2018			
HPV					

For more information regarding required immunizations, please visit the Massachusetts Department of Public Health website:
http://www.mass.gov/eohhs/docs/dph/cdc/immunization/guidelines-childhood.pdf

Healthcare provider name (please print) DAVID M. LAUREN Provider signature _____

Address _____
David M. Lauren, D.O.
License # 047449 (CT)
AFC Urgent Care
3000 Summer Street, Stamford, CT 06905
Phone: 203.969.2000 I Fax: 203.504.8723

Telephone _____ Fax _____ Date 5/13/2018

Student name Nguyen Arthur Date of Physical 05/13/18
(Please print) Last First Middle Initial

Male/Female/Other Height 5'3 Weight 135lb Blood Pressure 106/58 Pulse 48
(Please circle)

Please circle

1) Does student have any current or chronic medical conditions? Yes No

If yes, please explain _____

2) *Does student have any past or present mental health concerns*
(i.e., depression, anxiety, ADHD, substance abuse, eating disorders, etc.)? Yes No

If yes, please explain _____

3) Does student have any restrictions or limitations with regard to participation in sports/exercise?If yes, please circle one of following, and provide reason: Yes No

Pending further evaluation Restricted from all sports Restricted from certain sports

Reason_____

4) Do you have additional specific recommendations regarding the medical care of this student? Yes No

If yes, please explain_____

5) Does student have any known serious allergies to food, substances, bees/insects, or medications? Yes No

If yes, please list allergies _____

Do student's allergies require they carry an EpiPen? Yes No

*If yes, the child is required to have 2 current Epinephrine Auto-Injector's while on campus

6) Please list all medications and their doses:

None

7) Are there any pertinent abnormal findings on this student's exam? Yes No

If yes, please explain _____

Based on my physical exam, this student is cleared to participate in all school activities. Any exceptions are noted above.

Healthcare provider name (please print) DAVID M. LAUREN Provider signature _____

Adress _____

David M. Lauren, D.O.
License # 047449 (CT)
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3000 Summer Street, Stamford, CT 06905
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Telephone _____ Fax _____ Date 5/13/2018

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Thank you for your assistance.

URGENT CARE
american family care

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Stamford, CT 06905
Phone: (203) 969-2000
Fax: (203) 504-8733
Doctorsexpressstamford.com

PPD TEST

Please make sure to read the below statement regarding the time to return for your PPD results.

Return within 48-72 hours from the date of injection.

I. Patient Information

Last Name

Patient: Nguyen, Arthur
Date: 5/13/2018 Patient ID: 38,475
DOB: 05/13/04 Age: 14 Sex: M
Provider: Room, Waiting

D.B.

Social Security Number

II. Tuberculosis Test Results

1 Step TB

Date/Time	Arm	Lot#	Expiration	Manufacturer	Administered By:
5/13/18 12pm	R fa	CSU7CAA	7/30/20	sanofi pasteur	Monica B
Date/Time	**Results (mm)**			**Results Read/Resulted By:**	
5/15/18 6:12pm	Ø mm Negative R.F.A			A Pauline LPN	

Chest X-Ray: is ***only*** needed if you have had a prior positive PPD. For previously known or new positive reactors please complete the following. ***This report must state that the reason for the CXR is due to a positive PPD.***

Chest X-ray: Date:_____ Results:_____ Other: Date:_____ Results:_____

Physician or Nurse Signature: Monica Burrows **Date:** 5/13/18

Patient Signature: _____ **Date:** 5/13/18

URGENT CARE
american family care

3000 Summer Street
Stamford, CT 06905

phone: 203.969.2000 • fax: 203.504.8733

Monday - Friday: 8:00 AM - 8:00 PM
Saturday - Sunday: 8:00 AM - 5:00 PM

IPV
Hep A #2
Varicella
Hep B #3

TB Skin Test Questionnaire

Category 1

Nurses: For these patients, a reaction of > 5mm is considered positive

Have you had close contact to individuals with known or suspected infectious TB (tuberculosis) within the past 2 years?	☐ Yes	☑ No
Do you have active TB?	☐ Yes	☑ No
Do you have HIV infection?	☐ Yes	☑ No
Have you had a chest x-ray that showed any scarring consistent with prior TB?	☐ Yes	☑ No
Have you had an organ transplantation?	☐ Yes	☑ No
Is your immune system suppressed?	☐ Yes	☑ No
Have you taken more than 15 mg per day of Prednisone for one month or longer?	☐ Yes	☑ No
Do you take, or are you considering taking, tumor necrosis factor (TNF) inhibitors such as etanercept (Enbrel®), infliximab (Remicade®), adalimumab (Humira®) or anakinra (Kineret™)?	☐ Yes	☑ No

Category 2

Nurses: For these patients, a reaction of > 10mm is considered positive

Are you a child younger than 4 years of age?	☐ Yes	☑ No
Were you born in Asia, Africa, the Caribbean, Latin America, Mexico, South America, the Pacific Islands, or Eastern Europe?	☑ Yes	☐ No
Have you spent more than a month, cumulatively, in any of the above-mentioned countries?	☐ Yes	☑ No
Do you inject illicit drugs or use crack cocaine?	☐ Yes	☑ No
Do you have diabetes, chronic malabsorption syndrome, chronic renal failure, leukemia, lymphoma, Hodgkin's disease, cancer of the head or neck, scoliosis, gastrectomy, jejunoileal bypass, or have you experienced weight loss of greater than 10%?	☐ Yes	☑ No
Are you a resident or a staff member in a long-term care facility?	☐ Yes	☑ No
Are you a health care worker with direct patient contact?	☐ Yes	☑ No
Are you an inmate in the Department of Corrections?	☐ Yes	☑ No
Are you a staff member with direct inmate contact in the Department of Corrections or similar facilities?	☐ Yes	☑ No
Are you an employee of an HIV/AIDS adult care facility?	☐ Yes	☑ No
Are you an employee or volunteer at a homeless shelter?	☐ Yes	☑ No
Are you a staff member in a mycobacteriology lab?	☐ Yes	☑ No
Are you a child or adolescent exposed to the homeless, substance abusers, incarcerated people, or HIV positive patients?	☐ Yes	☑ No

Category 3

Patients who answered "no" to all the questions above are considered positive for a reaction > 15mm. If less than 15mm, they are negative

I have answered all of the questions above accurately and to the best of my knowledge.

Patient or Guardian Signature

05 / 13 / 18
Date

Updated 4/08/14

Student Name: Arthur Nguyen **Birth Date:** 5/13/04 HAR-3 REV. 4/2012

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*10/03/04	*12/05/04	*12/18/05	*3/6/06		
DT/Td						
Tdap	*9/26/15				Required for 7th grade entry	
IPV/OPV	*10/03/04	*12/05/04	*12/18/05	3/6/06		
MMR	*06/11/05	*12/18/05	3/6/06		Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*10/03/04	12/05/04	12/18/05	3/6/06	PK and K (Students under age 5)	
Hep A	*9/26/15	*			PK and K (born 1/1/2007 or later)	
Hep B	*5/13/04	*3/2/04	*		Required PK-12th grade	
Varicella	*1/8/06	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*1/8/06				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____

Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 1-6

- DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which must be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart or verification of disease*.

* **Verification of disease:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nation-wide shortage of supply for such vaccine.

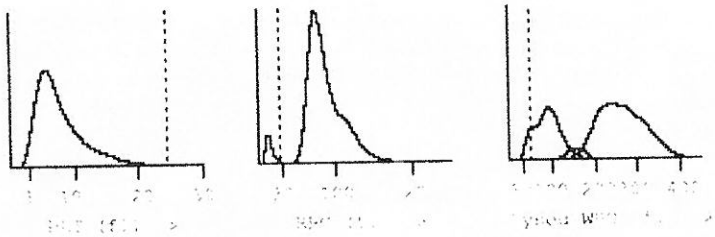
Francis J. Forno, D.O.
License #: 000495
Doctors Express Stamford
3000 Summer Street
Stamford, CT 06905
Ph: (203) 969-2000 F: (203) 504-5733

Initial/Signature of health care provider MD / DO / APRN / PA — Date Signed 9/26/15 — Printed/Stamped Provider Name and Phone Number

Doctors Express Stamford
3000 Summer St.
Stamford, CT 06905
(203) 969-2000

ID = 38475
ID2 =
SEQ = 2266 BLOOD MC
DATE= 09/26/2015
TIME= 09:47:56 Normal ranges

WBC =	8.4	$10^3/l$	3.5	:	10.0
LYM%=	27.3	%	15.0	:	50.0
MID%=	7.1	%	2.0	:	15.0
GRA%=	65.6	%	35.0	:	80.0
LYM =	2.3	$10^3/l$	0.5	:	5.0
MID =	0.6	$10^3/l$	0.1	:	1.5
GRAN=	5.5	$10^3/l$	1.2	:	8.0
RBC =	4.90	$10^6/l$	3.50	:	5.50
HGB =	14.1	g/dl	11.5	:	16.5
HCT =	41.7	%	35.0	:	55.0
MCV =	85.1	fl	75.0	:	100.0
MCH =	28.9	pg	25.0	:	35.0
MCHC=	33.9	g/dl	31.0	:	38.0
RDW%=	13.3	%	11.0	:	16.0
PLT =	257	$10^3/l$	100	:	400
MPV = L	7.6	fl	8.0	:	11.0



Tech:_____

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Immunization Record
Fiche d'immunisation

Name / Nom: NGUYEN ARTHUR

Date of Birth / Date de naissance: 2004/05/13 (yyyy/mm/dd) (aaaa/mm/jj)

Ontario Health Card Number / Numéro de carte Santé de l'Ontario

Routine Immunizations/Vaccination systématique

Date (yyyy/mm/dd) (aaaa/mm/jj)	Diphtheria Diphtérie	Pertussis Coqueluche	Tetanus Tétanos	Polio - IPV Poliomyélite - VPI	Polio - OPV Poliomyélite - VPO	Hib *	Measles Rougeole	Mumps Oreillons	Rubella Rubéole	Hepatitis B Hépatite B	Given by: (physician name and telephone no.) / Vaccin administré par : (nom et numéro de tel. du médecin)
2004/10/03	✓	✓	✓	✓		✓					DR TO 242-7447
04/12/05	✓	✓	✓	✓		✓					
2005-06-11							✓	✓	✓		Meningite DR TO
2005-12-18	✓	✓	✓	✓		✓	✓	✓	✓		
2006-01-09											Prevenar
"											VARIVAX II
2006-3-6	✓	✓	✓	✓		✓	✓	✓	✓		DR NGUYEN
2008/6/14	Boostrix										[illegible]

* Hib – Haemophilus influenzae b
– specify vaccine given: H=HibTITER™; A=Act-HIB™; P=PedvaxHIB™; D=ProHiBiT™; O=Other/Unknown
– précisez le vaccin administré : H=HibTITER™; A=Act-HIB™; P=PedvaxHIB™; D=ProHIBiT™; O=autre/inconnu

Tuberculosis/Tuberculose

BCG Date (yyyy/mm/dd) (aaaa/mm/jj)	TB skin test result / Réaction cutanée à la tuberculine: Date (yyyy/mm/dd) (aaaa/mm/jj)	Size Taille (mm)	Interpretation Interprétation (pos/nég)

Comments/Remarques

2373-64 (00/03) 7530-4708

VICKY C. K. WON
9255 WOODBINE
MARKHAM, ON
Store # 0640

PERSONAI

ARTHUR
Allergies: N

PLEASE C

SHOPPERS DRUG MART
VICKY C. K. WONG DRUGS LTD.
9255 WOODBINE AVE MARKHAM, ON L6C 1Y9 CANADA
Store # 0640 Phone: 905-887-3000
Rx# 9377100 Ref:0 R.PH. M. NG
ARTHUR NGUYEN
FLU - AGRIFLU (NOVARTIS)

KEEP OUT OF REACH OF CHILDREN

FLU - AGRIFLU (NOVARTIS)

1 26 Oct 2014 02346850

BT1

VICKY C
9255 W
MARKH
Store #

OFFI

NGU
27 M
MAR
905-
R.PH

Dose Administered: ☐ 0.5 mL ☐ ____ mL
Route of Administration: ☐ IM ☐ ____
Site of Administration: Deltoid: ☐ Right ☐ Left
☐ Other: _____
Lot #: 147161 A

Date
Rx:
FLU

1
Pri

P
S

SHOPPERS DRUG MART

To be completed by the doctor/nurse giving the immunisation

Child's name _____ Date of birth _____

AGE	ANTIGEN	DATE GIVEN	BATCH NO	SIGNATURE
Birth	Hepatitis B	13/05/04		
2 months	DTPa Hepatitis B Hib Polio Other	0/8/04	AC16A002AA 10-2005	
4 months	DTPa Hepatitis B Hib Polio Other			
6 months	DTPa Hepatitis B Polio Other			
12 months	MMR Hib Meningococcal C Other			
18 months	DTPa Other			
4 years	DTPa MMR Polio			
10 years	Hepatitis B Hepatitis B Hepatitis B Other			
15 - 19 years	DT Other			

DTPa = Diphtheria, Tetanus & acellular Pertussis (whooping cough)
MMR = Measles, Mumps, Rubella (german measles)
Not necessary for children who have received a course of hepatitis B vaccine as baby or young child

To be completed by the doctor/nurse giving the immunisation.

Child's name _____ Date of birth _____

AGE	ANTIGEN	DATE GIVEN	BATCH NO	SIGNATURE
Birth	Hepatitis B	13/05/04		
2 months	DTPa Hepatitis B Hib Polio Other	0/8/04	AC16A002AA 10-2005	
4 months	DTPa Hepatitis B Hib Polio Other			
6 months	DTPa Hepatitis B Polio Other			
12 months	MMR Hib Meningococcal C Other			
18 months	DTPa Other			
4 years	DTPa MMR Polio			
10 years	Hepatitis B Hepatitis B Hepatitis B Other			
15 - 19 years	DT Other			

DTPa = Diphtheria, Tetanus & acellular Pertussis (whooping cough)
MMR = Measles, Mumps, Rubella (german measles)
Not necessary for children who have received a course of hepatitis B vaccine as baby or young child

95

URGENT CARE
american family care

3000 Summer Street
Stamford, CT 06830
Phone: 203-969-2000
Fax: 203-504-8733

Vaccine Report

Printed Date: 5/13/2018

Patient: Arthur Nguyen
DOB: 05/13/2004
Sex: M

Address: 12 Fairfeld Ave
DARIEN, CT, 06820
Home Phone: (647) 974-6269

Date	Vaccine	Notes
09/26/2015	Tdap	Route: Intramuscular Lot number: U5264AA Expiration date: 01/15/2018 Site: Right Deltoid Abnormal: no Notes: NDC#:49281-400-58
02/06/2018	Flu, shot	Route: Intramuscular Lot number: 196498 Expiration date: 06/01/2018 Site: Left Deltoid Patient action: Accepted Abnormal: no
05/13/2018	Varicella	Route: Subcutaneous Lot number: n028715 Expiration date: 10/13/2019 Site: Right Arm Patient action: Accepted Abnormal: no
05/13/2018	Polio	Route: Intramuscular Lot number: n1j451m Expiration date: 10/05/2019 Site: Right Deltoid Patient action: Accepted Abnormal: no
05/13/2018	MCV4	Route: Intramuscular Lot number: u5752ab Expiration date: 11/16/2018 Site: Left Deltoid Patient action: Accepted Abnormal: no
05/13/2018	Hep B	Route: Intramuscular Lot number: p7ee2 Expiration date: 03/09/2019 Site: Left Deltoid Patient action: Accepted Abnormal: no
05/13/2018	Hep A	Route: Intramuscular Lot number: 3md4r Expiration date: 09/18/2018 Site: Left Deltoid Patient action: Accepted Abnormal: no

09/26/2015 Hep A

Route: Intramuscular
Lot number: L018499
Expiration date: 02/25/2017
Site: Left Deltoid
Patient action: Accepted
Abnormal: no

Notes: NDC#:0006-4831-01