



HEALTH EXAMINATION FORM

LAST NAME: Beyer FIRST NAME: Audrey TSCC ID #: _____ PHONE NUMBER: _____

THE FOLLOWING INFORMATION MUST BE COMPLETED BY A PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

Allergies (Food Drug Latex, etc.) <u>NKDA</u>								
C O M P L E T E	Height	<u>66 inch</u>	Weight	<u>122 lbs.</u>	BP	<u>122/80</u>	Pulse	<u>89</u>
	Vision Right	<u>20</u>	Left	<u>20</u>	Corrected:	Y ☐ N ☒		

The student has been diagnosed with a chronic/serious medical condition(s)? (Ex. Diabetes, hypertension, seizure disorders, etc.?) ☒ Yes ☐ No

If yes, please list: dysautonomia
Is/are the condition(s) being presently controlled or treated? ☒ Yes ☐ No If yes, please describe: 0 med needed

The student has been diagnosed with a psychiatric/mental condition(s)? (Ex. Bipolar, depression, chemical dependency, etc.) ☐ Yes ☒ No

Is/are the condition(s) being presently controlled or treated? ☐ Yes ☐ No If yes, please describe: _____

The student is taking prescribed medications on a regular basis? ☐ Yes ☒ No

If yes, please list: _____

On the basis of my examination on this day April 28, 2022, I approve the student's participation in Clinical Education.
month, day, year

☐ Yes ☐ No ☐ Limited - If limited, please describe: _____

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Maranda Fair, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fair CRNP

Provider:
Please place office stamp
here (if possible) for
validation purposes.

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



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Beyer FIRST NAME: Aubrey TSCC ID #: _____

MEASLES/MUMPS/RUBELLA (MMR) TITER - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

HAVE YOU RECEIVED YOUR MMR IMMUNIZATION IN THE PAST? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

STEP 1 - IF YOU HAVE COMPLETED AN MMR IMMUNIZATION IN THE PAST - HAVE A TITER DRAWN - AND HAVE YOUR PROVIDER COMPLETE THE FOLLOWING. IF ANY RESULTS ARE NEGATIVE - SEE STEP 2 - RE-VACCINATION IS REQUIRED.

DATE OF MEASLES (RUBEOLA) TITER: 4/29/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)
 DATE OF MUMPS TITER: 4/29/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)
 DATE OF RUBELLA (MEASLES) TITER: 4/29/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.7 AI) (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Maranda Fain, CNP

AUBURN UNIVERSITY MONTGOMERY

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023**

IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!

IF TITER RESULTS ARE NEGATIVE OR IF YOU HAVE NEVER BEEN VACCINATED - COMPLETE STEP 2 BELOW.

MEASLES, MUMPS, RUBELLA (MMR) VACCINATION

STEP 2 - IF YOU HAVE NOT HAD AN MMR IMMUNIZATION OR IF YOU HAVE A NEGATIVE TITER - IMMUNIZATION IS REQUIRED. A HEALTHCARE PROVIDER MAY RECOMMEND A BOOSTER. IF A BOOSTER IS PERFORMED COMPLETE DOSE #1 LINE ITEM.

DOSE # 1	MEASLES (RUBEOLA)	DATE: _____	DOSE # 2	MEASLES (RUBEOLA)	DATE: _____
DOSE # 1	MUMPS	DATE: _____	DOSE # 2	MUMPS	DATE: _____
DOSE # 1	RUBELLA (MEASLES)	DATE: _____	DOSE # 2	RUBELLA (MEASLES)	DATE: _____

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

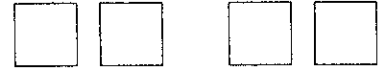
PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

(Faint signature of Maranda Fain, CNP)

AFTER COMPLETION OF STEP 2 (2-DOSE SERIES) OR BOOSTER, HAVE A TITER DRAWN FOR EACH VACCINATION RECEIVED IN STEP 2 TO DOCUMENT IMMUNITY:

DATE OF MEASLES TITER: _____ POSITIVE? _____ NEGATIVE? _____ (please identify results with a ✓)
 DATE OF MUMPS TITER: _____ POSITIVE? _____ NEGATIVE? _____ (please identify results with a ✓)
 DATE OF RUBELLA TITER: _____ POSITIVE? _____ NEGATIVE? _____ (please identify results with a ✓)
 PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Beyer FIRST NAME: Aubrey TSCC ID #: _____

VARICELLA/CHICKEN POX IMMUNIZATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

HAVE YOU RECEIVED YOUR VARICELLA/CHICKEN POX IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

STEP 1 - IF YOU HAVE PREVIOUSLY COMPLETED A VARICELLA/CHICKEN POX IMMUNIZATION OR HAVE HAD THE CHICKEN POX - HAVE A TITER DRAWN AND HAVE YOUR PROVIDER COMPLETE THE FOLLOWING. IF RESULTS ARE NEGATIVE - SEE STEP 2 - RE-IMMUNIZATION IS REQUIRED.

DATE OF VARICELLA TITER: 4/28/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) maranda Fuin, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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P.O. BOX 244023

IF YOU HAVE POSITIVE RESULTS, YOU ARE DONE!

IF YOUR RESULTS ARE NEGATIVE - COMPLETE STEP 2 BELOW.

STEP 2 - IF YOU HAVE NOT HAD A VARICELLA/CHICKEN POX VACCINATION OR A NEGATIVE TITER RESULT - VARICELLA IMMUNIZATION OR BOOSTER IS REQUIRED. A HEALTHCARE PROVIDER MAY RECOMMEND A BOOSTER. IF A BOOSTER IS PERFORMED COMPLETE VACCINATION #1 ONLY.

VARICELLA/CHICKEN POX VACCINE

DATE OF VARICELLA VACCINE #1: _____

DATE OF VARICELLA VACCINE #2: _____

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

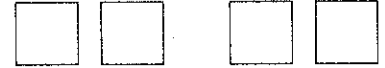
Provider
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AFTER COMPLETION OF 2-PART SERIES OR BOOSTER, HAVE A TITER DRAWN FOR VARICELLA ANTIBODY TO DOCUMENT IMMUNITY:

DATE OF TITER: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



LAST NAME: Beyer FIRST NAME: Andrey TSCC ID #: _____

A TDAP BOOSTER IS REQUIRED EVERY 10 YEARS AFTER INITIAL VACCINE.

DATE OF ORIGINAL TDAP VACCINATION: 01/29/02 DATE OF MOST RECENT BOOSTER: 01/2002

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

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HEPATITIS B IMMUNIZATION

LAST NAME: Beyer

FIRST NAME: Aubrey

TSCC ID #: _____

HAVE YOU COMPLETED A SERIES OF HEPATITIS B IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

HEPATITIS B TITER - TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER.

STEP 1 - IF YOU HAVE COMPLETED A HEPATITIS B SERIES IN THE PAST - HAVE A TITER DRAWN AND COMPLETE THE FOLLOWING.
PLEASE NOTE THAT IF YOUR TITER IS NEGATIVE YOU MUST COMPLETE STEP 2.

DATE OF TITER: 4/28/2022 POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? ☒ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Brandi Fain, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

M. Fair, CRNP
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IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!
IF YOUR RESULTS ARE NEGATIVE - COMPLETE STEP 2 BELOW.

STEP 2 - IF YOU HAVE NOT COMPLETED A HEPATITIS B IMMUNIZATION OR IF YOU HAD A NEGATIVE TITER - A FULL 3-PART SERIES IMMUNIZATION IS REQUIRED.

1ST VACCINATION DATE: 5/12/2022 AUBURN UNIVERSITY MONTGOMERY
PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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STUDENT HEALTH CENTER
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2ND VACCINATION DATE: _____
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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3RD VACCINATION DATE: _____
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
Please place office stamp
here (if possible) for
validation purposes.

AFTER COMPLETION OF THE FULL 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B ANTIBODY TO DOCUMENT IMMUNITY:

DATE OF TITER: _____ POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? _____ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

**TUBERCULOSIS (TB) SKIN TEST**

LAST NAME:

Beyer

FIRST NAME:

Aubrey

TSCC ID #:

TUBERCULIN (TB) 2 STEP MANTOUX SKIN TEST - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

STEP 1 - TEST #1:

NAME OF PERSON ADMINISTERING:

miranda Bicknell

DATE ADMINISTERED (TEST #1):

5/2/22

LOT #:

CS805AA

EXPIRATION DATE:

3/17/2023

DATE READ:

5/14/22

(MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 1 RESULTS:

☐ POSITIVE☒ NEGATIVE☐ REDNESS

(please identify results with a ✓)

☒ mm

(please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

M. Fair camp

On the date read (48-72 hrs after it is administered), your provider will evaluate, measure, and interpret the area. Your provider will document the millimeters (e.g. 0 mm, 4 mm, 12 mm) and if the 1st TST is negative, you will return for the 2nd test in 7-21 days. If the 1st test is positive, you should see your provider for additional evaluation and treatment.

IF TEST #1 WAS NEGATIVE - WAIT 7-21 DAYS BEFORE COMPLETING STEP 2**STEP 2 - TEST #2 - 7 - 21 DAYS AFTER STEP 1**

NAME OF PERSON ADMINISTERING:

miranda Bicknell RN

DATE ADMINISTERED (TEST #2):

5/19/2022

LOT #:

CS805AA

EXPIRATION DATE:

3/17/2023

DATE READ:

5/19/22

(MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 2 RESULTS:

☐ POSITIVE☒ NEGATIVE☐ REDNESS

(please identify results with a ✓)

☒ mm

(please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

M. Fair camp

Provider:

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On the date read (48-72 hrs after TEST #2), your provider will evaluate, measure, and interpret the TST. Document the millimeters (e.g. 0 mm, 4 mm, 12 mm).
 If the 2nd TST is negative - you are done!

On the date read (48-72 hrs after TEST #2), your provider will evaluate, measure, and interpret the TST. Document the millimeters (e.g. 0 mm, 4 mm, 12 mm).
 If the 2nd TST is positive, you should see your provider for additional information & treatment.

IMPORTANT NOTE:

If a TB skin test cannot be performed due to past + test or BCG vaccination:

1) Your provider will likely order a chest x-ray and you will provide the program with a Radiologist's report - OR

2) Your provider (on provider letterhead) can document that you are free from TB and do not need a 2-step TB test or chest x-ray