



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Owens

FIRST NAME: Laverne

TSSC 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: 12/1/20 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Amy Morris RN-BC

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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

IF YOUR TITER RESULTS ARE POSITIVE - 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:
Please place office stamp
here (if possible) for
validation purposes.

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 $\checkmark$)

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



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Owens

FIRST NAME: Lauren

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: Amy Morris

DATE ADMINISTERED (TEST #1): 11/30/20 LOT #: C573SAA

EXPIRATION DATE: 7/28/22

DATE READ: 12/2/20 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 1 RESULTS: _____ POSITIVE ☒ _____ NEGATIVE _____ REDNESS
_____ mm (please provide measure in millimeters)

(please identify results with a ✓)
**AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023**

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Amy Morris RN-BC

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: _____

DATE ADMINISTERED (TEST #2): _____ LOT #: _____

EXPIRATION DATE: _____

DATE READ: _____ (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 _____

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:



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Owens

FIRST NAME: Lauren

TSCC ID #: _____

TETANUS, DIPHTHERIA, & PERTUSSIS (TDAP) VACCINATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

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

DATE OF ORIGINAL TDAP VACCINATION: 7/31/07

DATE OF MOST RECENT BOOSTER: 11/30/20

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Amy Morris

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Owens

FIRST NAME: Lauren

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: 12/1/20 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

DATE OF MUMPS TITER: 12/1/20 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

DATE OF RUBELLA (MEASLES) TITER: 12/1/20 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a ☒)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Amy Morris

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
here (if possible) for validation purposes
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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 _____

Provider:
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validation purposes.

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 _____



INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Owens FIRST NAME: Lauren TSCC ID #: _____

SEASONAL INFLUENZA (FLU SHOT) VACCINATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE

FLU SEASON TYPICALLY BEGINS MID-SEPTEMBER
VACCINATIONS ARE NOT AVAILABLE BEFORE THIS TIME

DATE ADMINISTERED: 11/30/20 MANUFACTURER: GSK LOT #: N549A EXPIRATION DATE: 6/30/21

SITE OF INJECTION: _____ LEFT DELTOID ☒ RIGHT DELTOID (please identify location of injection with a ✓)

PROVIDER - PLEASE PRINT THE FOLLOWING INFORMATION:

NAME OF PERSON ADMINISTERING: Amy Morris CREDENTIALS OF PERSON ADMINISTERING: RN-BC

SIGNATURE OF PERSON ADMINISTERING: [Signature]

NAME OF OFFICE OR FACILITY: _____ PHONE #: 334/244/3281

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

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



HEPATITIS B IMMUNIZATION

LAST NAME: Owens FIRST NAME: Lawren 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: _____ POSITIVE? _____ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? _____ (anti-HBs ≤ 10 mIU/mL) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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

**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: 11/30/20

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: [Signature]

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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

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 ≥ 10 mIU/mL) NEGATIVE? _____ (anti-HBs ≤ 10 mIU/mL) (please identify results with a $\checkmark$)

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