

AUM Student Health Services

Immunization Record

Patient Name: Kendra Morris

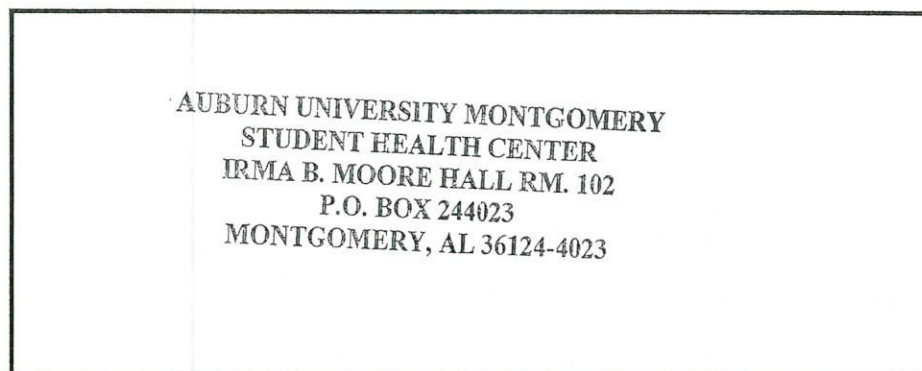
Birthdate: 8/2/78

Allergies/Medical Alert: Cefprozil, Amoxicillin, Biaxin, Levofloxacin
(no longer azithromycin)

Immunization	Date	Site	Dose	MFR	Comments	V.V.S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B							
Other							

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	2-3-25	2/5/25	Imm Sanofi Negative		2CA50C1	exp 5/26 QFA	DM/MS

Initials	Signature	Initials	Signature
MS DM	MS in [Signature] Michael Marzetta	J. Hamilton, CPH	VB



STAMP ABOVE



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Kendra Morris

Date of Birth: 8/2/78

Student Number: _____

Please mark "yes" or "no" to the following questions.

YES NO

1. Do you have a cough that has lasted longer than 3 weeks?		X
2. Have you coughed up blood or mucus?		X
3. Have you had fever, chills, or night sweats?		X
4. Have you had unintentional weight loss?		X
5. Have you been feeling very tired?		X
6. Have you lost your appetite?		X
7. Have you ever had a positive TB skin test result or Positive interferon gamma release assay (IGRA) result? If so, when?		X
8. Have you ever had an abnormal chest x-ray?		X
9. Have you recently had the mucus coughed up tested for TB?		X
10. Have you ever been told you had TB or latent TB?		X
11. Have you ever taken medicine for TB?		X
12. Have you ever lived with or had close contact with someone who had TB?		X
13. Do you currently have a rash on either forearm?		X
14. Are you immunocompromised? (Steroids, chemotherapy, or other?)		X
15. Have you received a live vaccine in the past 30 days?		X

All TB skin test and Chest x-rays must be performed in the U.S. to be valid.

I attest the above is true and accurate to the best of my knowledge.

Patient Signature: Kendra Morris

Date: 2-3-25

Provider Signature: Alidia Mangata

Date: 2-3-25