



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Taylor

FIRST NAME: Danielle

TSCC ID #: A02318443

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 RN

DATE ADMINISTERED (TEST #1): 11/29/22

LOT #: C5805AA (U)FA

EXPIRATION DATE: 3/17/23

DATE READ: 12/1/22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 1 RESULTS: ☐ POSITIVE ☒ NEGATIVE ☐ REDNESS (please identify results with a ✓)
0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Rob Blackwelder RN

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): 12/16/2022 LOT #: C5806AA (U)FA

EXPIRATION DATE: 3/25/23

DATE READ: 12/18/22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 2 RESULTS: ☐ POSITIVE ☒ NEGATIVE ☐ REDNESS (please identify results with a ✓)
0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Rob Blackwelder RN

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

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validation purposes.

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



HEPATITIS B IMMUNIZATION

LAST NAME: Taylor

FIRST NAME: Danielle

TSCC ID #: A02318443

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

HEPATITIS B IMMUNIZATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

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: 11/29/22 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) Robin Blackwell CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell 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: 12/14/2022

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: Robin Blackwell CRNP

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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validation purposes.

AFTER COMPLETION OF 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B SURFACE ANTIGENS (anti-HBs) 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 ✓)



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Danielle Taylor DOB: 11-09-2001 Phone: (334) -717-4752

Mailing Address: 720 Maryethel Dr. City: Montgomery ST: AL Zip: 36109

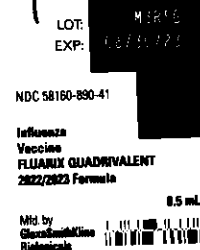
Insurance Company: BCBS Subscriber name: _____ DOB: _____

Insurance Contract Number: _____ Group number: _____

Screening Questions:	Yes	No	Don't Know
1) Are you sick today? (cold, fever, acute illness)	☐	☒	☐
2) Do you have allergies to any foods, medications or latex? (For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations) List <u>peanuts</u>	☒	☐	☐
3) Have you had any serious reactions from a vaccine?	☐	☒	☐
4) Have you been diagnosed with Guillain-Barre syndrome?	☐	☒	☐

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request,

Signature Danielle Taylor Date 11/29/2022
Administration Date 11/29/2022 Route: IM LD or RD Volume: 0.5ml
Administrator M. Bicknell, RN VIS Date 08/15/2019
Manufacturer: GSK Fluarix® Quadrivalent Lot # M3R5B Expires 06/30/2023
Temp: see chart





HEALTH EXAMINATION FORM

LAST NAME: Taylor FIRST NAME: Danielle TSCC ID #: A02318443 PHONE NUMBER: (334)-717-4752

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

Allergies (Food/Drug/Latex, etc.) <u>Peanuts</u>								
C O M P L E T E	Height	<u>64</u>	Weight	<u>157.5</u>	BP	<u>120/80</u>	Pulse	<u>59</u>
	Vision Right 20/	<u>20</u>	Left 20/	<u>25</u>	Corrected:	☒ Yes ☐ No		
					NORMAL	ABNORMAL FINDINGS		
	CBC				☒			
	Cardiovascular				☒			
	Pulses				☒			
	Heart				☒			
	Lungs				☒			
	Skin				☒			
	E.N.T.				☒			
Gastrointestinal				☒				
Musculoskeletal				☒				
Neurological				☒				
Other								

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

If yes, please list: Asthma

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

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: Albuterol Inhaler (PRN)

On the basis of my examination on this day, 12.1.22, I approve the student's participation in Clinical Education.
month, day, year

☒ Yes ☐ No ☐ Limited - If limited, please describe: R

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Robin B. Bickwell CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin B. Bickwell CRNP

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MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Taylor FIRST NAME: Danielle TSCC ID #: A02318443

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

HAVE YOU RECEIVED YOUR MMR IMMUNIZATION? 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-IMMUNIZATION IS REQUIRED.

DOSE #1

DATE OF MEASLES (RUBEOLA) TITER: 11/9/12 **POSITIVE?** (≥ 1.1 AI) **NEGATIVE?** (≤ 0.8 AI) (please identify results with a ✓) **POSITIVE?**
 DATE OF MUMPS TITER: 11/9/12 (≥ 1.1 AI) **NEGATIVE?** (≤ 0.8 AI) (please identify results with a ✓) **POSITIVE?** (≥ 1.1 AI)
 DATE OF RUBELLA (MEASLES) TITER: 11/9/12 **NEGATIVE?** (≤ 0.7 AI) (please identify results with a ✓)

positive titer for mmr

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Robin Blackwell CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Rob Blackwell CRNP

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**IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!
 IF TITER RESULTS ARE NEGATIVE - 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.

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 _____

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VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Taylor

FIRST NAME: Danielle

TSCC ID #: A02318443

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: 11/29/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Robin Blackwell CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell 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 HAD A VARICELLA/CHICKEN POX VACCINATION OR A NEGATIVE TITER RESULT - VARICELLA IMMUNIZATION IS REQUIRED.

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 _____

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ANNUAL TUBERCULOSIS (TB) SKIN TEST

"TO BE COMPLETED 1 YEAR AFTER ACCEPTANCE INTO THE PROGRAM"

LAST NAME: Taylor

FIRST NAME: Danielle

TSCC ID #: A02318443

TUBERCULIN (TB) 1 STEP SKIN TEST - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

NAME OF PERSON ADMINISTERING: _____

DATE ADMINISTERED (TEST #1): _____

LOT #: _____

EXPIRATION DATE: _____

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

TEST RESULTS: ☐ POSITIVE ☐ NEGATIVE ☐ REDNESS (please identify results with a ✓)
 _____ mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Taylor

FIRST NAME: Danielle

TSCC ID #: A02318443

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: 11/29/22 MANUFACTURER: GSK LOT #: m325B EXPIRATION DATE: 03/01/23

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

PROVIDER - PLEASE PRINT THE FOLLOWING INFORMATION:

NAME OF PERSON ADMINISTERING: Miranda Bicknell CREDENTIALS OF PERSON ADMINISTERING: RN

SIGNATURE OF PERSON ADMINISTERING: MB Bicknell RN

NAME OF OFFICE OR FACILITY: AUM PHONE #: (334) 244-3281

STREET ADDRESS: 7461 East Dr. CITY: Montgomery STATE: AL ZIP CODE: 36117

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TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Taylor

FIRST NAME: Danielle

TSCC ID #: A02318443

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: 11/01/02 & DTaP DATE OF MOST RECENT BOOSTER: 11/29/02

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Robin Blackwell, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CRNP

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ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: TAYLOR, DANIELLE M
 DOB: 11/09/2001
 Chart #:
 Date of Service: 11/29/2022

Vaccine Family	Type of Vaccine (no Brand Name)	Date Given (mm/dd/yy)	Age at Adm	Dose (cc/mL)	Route & Site	Mfr.	Lot #	VIS Date	Vaccinator Signature
Tetanus, Diphtheria, (Pertussis) (e.g. Td, Tdap)	DTAP	01/10/02	2 m	0.5					
	DTAP	01/11/02	2 m	0.5					
	DTAP	03/13/02	4 m	0.5					
	DTAP	04/08/02	4 m	0.5					
	DTAP	05/20/02	6 m	0.5					OUTSIDE CLINIC
	DTAP	06/10/02	7 m	0.5					
	DTAP	03/03/03	15 m	0.5					
	DTAP	01/27/04	2 y	0.5					OUTSIDE CLINIC
	DTAP	11/10/05	4 y	0.5					
	DTAP	01/11/06	4 y	0.5					
	TDAP	11/12/12	11 y	0.5					
Hepatitis A (e.g., HepA, HepA-HepB)	HEP A	03/20/07	5 y	0.5					
	HEP A	10/21/10	8 y	0.5					OUTSIDE CLINIC
	HEP A	12/01/11	10 y	0.5					OUTSIDE CLINIC
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PED	11/11/01	0 m	0.5					
	HEP B ADOL/PED	12/10/01	1 m	0.5					
	HEP B - HIB	01/10/02	2 m	0.5					
	HEP B - HIB	04/08/02	4 m	0.5					
	HEP B ADOL/PED	05/20/02	6 m	0.5					OUTSIDE CLINIC
	HEP B - HIB	12/05/02	12 m	0.5					
Human Papillomavirus (e.g., HPV)	HPV (GARDASIL)	11/12/12	11 y	0.5					
Measles, Mumps, Rubella (MMR, MMRV)	MMR	11/19/02	12 m	0.5					OUTSIDE CLINIC
	MMR	12/05/02	12 m	0.5					
	MMR	01/11/06	4 y	0.5					
	MMR	03/13/07	5 y	0.5					
Meningococcal (MCV4, MPSV4)	MENINGOCOCCAL UNS	11/12/12	11 y	0.5					
Pneumococcal (e.g. PCV, PPV)	PCV7	03/13/02	4 m	0.5					
	PCV7	05/20/02	6 m	0.5					OUTSIDE CLINIC
	PCV7	11/18/04	3 y	0.5					
Polio (e.g., IPV, DTaP-HepB-Hib)	IPV	01/10/02	2 m	0.5					
	IPV	01/11/02	2 m	0.5					
	IPV	03/13/02	4 m	0.5					
	IPV	04/08/02	4 m	0.5					
	IPV	06/10/02	7 m	0.5					
	IPV	01/27/04	2 y	0.5					OUTSIDE CLINIC
	IPV	11/10/05	4 y	0.5					
	IPV	01/11/06	4 y	0.5					
Varicella (Var, MMRV)	VARICELLA	11/19/02	12 m	0.5					OUTSIDE CLINIC
	VARICELLA	12/05/02	12 m	0.5					
	VARICELLA	06/09/08	6 y	0.5					
Influenza (e.g., TIV, LAIV)	IV3 SEASONAL	12/01/11	10 y	0.25 0.5					OUTSIDE CLINIC
	INFLUENZA SPLIT PSA	10/09/12	10 y	1.0		PMC			
	IV4 - P FREE	08/07/20	18 y	0.5	IM RD	PMC	UJ427AB		OUTSIDE CLINIC

Zoster									
Other	HIB (HBOC)	01/11/02	2 m						
	HIB (HBOC)	03/13/02	4 m						
	HIB (HBOC)	05/20/02	6 m						OUTSIDE CLINIC
	Pfizer Covid19	05/11/21	19 y		IM	PFR	EW0185		OUTSIDE CLINIC
	Pfizer Covid19	06/02/21	19 y		IM	PFR	EW0178		OUTSIDE CLINIC

WARHAWK HEALTH SERVICES
7461 EAST DRIVE
RM 102 MOORE HALL
MONTGOMERY, AL36117
334 2443281

PPD	Date	Results	PPD	Date	Results
Mantoux			Mantoux		
Mantoux			Mantoux		
Mantoux			Mantoux		

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Danielle Taylor

DATE OF BIRTH 11 / 09 / 2001
month day year

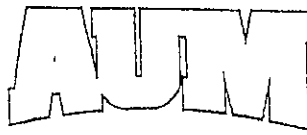
For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex? <u>neanuts</u>	☒	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, <u>asthma</u> , kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☒	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY Danielle Taylor DATE 11/29/2022
FORM REVIEWED BY WBS DATE 11/29/2022

Did you bring your immunization record card with you? yes ☐ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Danielle Taylor

Date of Birth: 11-09-2001

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?		
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: Danielle Taylor

Date: 11/29/2022

Provider Signature: [Signature]

Date: 11/29/2022

AUM Student Health Services

Immunization Record

Patient Name: Demelle Taylor

Birthdate: 11/9/01

Allergies/Medical Alert: peanuts

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap	11/29/22	(C) deltoid	LOT: [REDACTED] EXP: [REDACTED] NDC 58150-042-43 Tetanus Toxoid, Reduced Diphtheria Toxin and Acellular Pertussis Vaccine, Adsorbed BOCELVAX	[REDACTED]		8/16/22	WBS
Td Booster		Im	0.5 mL				
MMR			Mfr. by GlaxoSmithKline Biologicals	498018			
HEP A			LOT: [REDACTED] EXP: [REDACTED]				
HEP B	12/16/22	(C) deltoid	NDC 58150-021-43 Hepatitis B Vaccine (Recombinant) ENGRIX-B	[REDACTED]		10/15/22	WBS
Other		Im	20 mcg/mL				
			Mfr. by GlaxoSmithKline Biologicals	498702			

end Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	11/29/22	12/1/22	0mm	Sanofi	CS80SAA	exp. 3/17/23 (OFA)	WBS
	12/16/22	12/18/22	0mm	Sanofi	CS80VAA	exp. 3/15/23 (OFA)	WBS

Initials	Signature	Initials	Signature
WBS	WBS [Signature]		

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