



HEALTH EXAMINATION FORM

LAST NAME: Berry FIRST NAME: Lamaya TSCC ID #: A02099914 PHONE NUMBER: (334) 808-0988

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

Allergies (Food/Drug/Latex, etc.)								
C O M P L E T E	Height	<u>62</u>	Weight	<u>218.9</u>	BP		Pulse	<u>75</u>
	Vision Right 20	<u>15</u>	Left 20	<u>15</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: Asthma

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

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 pen

On the basis of my examination on this day 04/27/2022 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 Fain, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fain 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



HEPATITIS B IMMUNIZATION

LAST NAME: Berry FIRST NAME: Lamaya TSSC ID #: AD2099914

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: 4/27/22 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) Maranda Fain, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fain CRNP AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER

IRMA B. MOORE HALL RM. 102

P.O. BOX 244023

MONTGOMERY, AL 36124-4023

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: 4/29/2022

AUBURN UNIVERSITY MONTGOMERY

STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102

P.O. BOX 244023
MONTGOMERY, AL 36124-4023

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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

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

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) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Berry

FIRST NAME: Lamaya

TSCC ID #: A02099914

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: 4/27/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature] AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER

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

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 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) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Berry

FIRST NAME: Lamaya

TSCC ID #: A02099914

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: unknown

DATE OF MOST RECENT BOOSTER: 4/29/2022

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fain 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: Berry

FIRST NAME: Lamay a

TSCC ID #: A02099914

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: 4/27/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)
DATE OF MUMPS TITER: 4/27/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)
DATE OF RUBELLA (MEASLES) TITER: 4/27/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]
AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023

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

**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
Please place office stamp
here (if possible) for
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 $\checkmark$)
DATE OF MUMPS TITER: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a $\checkmark$)
DATE OF RUBELLA TITER: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Berry

FIRST NAME: Lamaya

TSCC ID #: A02099914

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): 4/27/2022 LOT #: C5805AA

EXPIRATION DATE: 3/17/2023

DATE READ: 4/29/22 (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 M. Jacamp

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: Doretha Marzette

DATE ADMINISTERED (TEST #2): 5/10/22 LOT #: C5805AA

EXPIRATION DATE: 3/17/2023

DATE READ: 5-12-22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 2 RESULTS: POSITIVE X NEGATIVE REDNESS (please identify results with a ✓)

0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Jacamp

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

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