



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Gunter

FIRST NAME: Kersie

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): 12/10/2022 LOT #: CS800AA (LFA)

EXPIRATION DATE: 3/29/2022

DATE READ: 12/8/22 (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

[Signature]

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

DATE ADMINISTERED (TEST #2): 12/15/2022 LOT #: CS800AA (LFA)

EXPIRATION DATE: exp 3/29/22

DATE READ: 12/15/22 (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

[Signature]

Provider:
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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:



HEPATITIS B IMMUNIZATION

LAST NAME: Gunter

FIRST NAME: Kelsie

TSCC ID #: A0217-108

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: 12/5/22 POSITIVE? ☒ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? ☒ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Stewan Wang, MD

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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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: 12/8/2022

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: [Signature]

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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: _____

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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 $\checkmark$)

**AUM Student Health Services
Immunization Record**

Patient Name: Kelsie Gunter

Birthdate: 7/17/97

Allergies/Medical Alert: NYA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B	12/8/2022	left deltoid	1m	LOT: 25K3M EXP: 06/02/24 NDC 50150-821-43 Hepatitis B Vaccine (Recombinant) ENGERIX-B 40mcg/mL Mfg. by GlaxoSmithKline Biologicals 495702		10/16/21	UNB
Other							

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	12/16/2022	12/18/22	0mm	Sano fi	C5800AA	exp 3/25/23 (CFA)	UNB
	12/15/2022	12/15/22	0mm	Sano fi	C5800AA	exp 5/25/23 (CFA)	UNB

Initials	Signature	Initials	Signature
UNB	UNB [Signature]		

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STAMP ABOVE



HEALTH EXAMINATION FORM

LAST NAME: Gunter FIRST NAME: Kelsie TSCC ID #: _____ PHONE NUMBER: _____

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

Allergies (Food/Drug/Latex, etc.) <u>NKA</u>				
C O M P L E T E	Height <u>57 in</u>	Weight <u>240.4</u>	BP <u>108/62</u>	Pulse <u>79</u>
	Vision Right 20/ <u>40</u>	Left 20/ <u>40</u>	Corrected: Y ☐ N ☒	
			NORMAL	ABNORMAL FINDINGS
	CBC		☒	
	Cardiovascular		☒	
	Pulses		☒	
	Heart		☒	
	Lungs		☒	
	Skin		☒	
	ENT		☒	
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: _____

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: _____

On the basis of my examination on this day 12/6/2022, I approve the student's participation in Clinical Education.
month, day, year

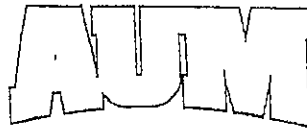
☒ Yes _____ No _____ Limited - If limited, please describe: _____

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Lindsey T. Barton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider:
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**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Kelsie Guntel

Date of Birth: 7/17/97

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

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: Kelsie Guntel

Date: 12/6/22

Provider Signature: MS [Signature]

Date: 12/6/22

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Keslie Gunter

DATE OF BIRTH 7/17/97
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?	☐	☒	☐
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, asthma, 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?	☒	☐	☐

Flu, TR skin test

FORM COMPLETED BY Keslie Gunter DATE _____

FORM REVIEWED BY MB [Signature] DATE 12/8/12

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.