



HEPATITIS B IMMUNIZATION

LAST NAME: Gulden FIRST NAME: Amanda TSCC ID #: _____

DOB: 2/12/91
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: 12/10/21 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) Melinda 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

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: 11/4/2022

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

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 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 ☒)

3) Cognitive/Critical Thinking

- a) Effectively read, write and comprehend the English language
- b) Consistently and dependably engage in the process of critical thinking in order to formulate and implement safe and ethical nursing decisions in a variety of health care settings
- c) Demonstrate satisfactory performance on written examinations including mathematical computations without a calculator
- d) Satisfactorily achieve the program objectives

4) Motor Function

- a) Handle small delicate equipment/objects without extraneous movement, contamination or destruction
- b) Move, position, turn, transfer, assist with lifting or lift and carry clients without injury to clients, self or others
- c) Maintain balance from any position
- d) Stand on both legs
- e) Coordinate hand/eye movements
- f) Push/pull heavy objects without injury to client, self or others
- g) Stand, bend, walk and/or sit for 6-12 hours in a clinical setting performing physical activities requiring energy without jeopardizing the safety of the client, self or others
- h) Walk without a cane, walker or crutches
- i) Function with hands free for nursing care and transporting items
- j) Transport self and client without the use of electrical devices
- k) Flex, abduct and rotate all joints freely
- l) Respond rapidly to emergency situations
- m) Maneuver in small areas
- n) Perform daily care functions for the client
- o) Coordinate fine and gross motor hand movements to provide safe effective nursing care
- p) Calibrate/use equipment
- q) Execute movement required to provide nursing care in all health care settings
- r) Perform CPR and physical assessment
- s) Operate a computer

5) Professional Behavior

- a) Convey caring, respect, sensitivity, tact, compassion, empathy, tolerance and a healthy attitude toward others
- b) Demonstrate a mentally healthy attitude that is age appropriate in relationship to the client
- c) Handle multiple tasks concurrently
- d) Perform safe, effective nursing care for clients in a caring context
- e) Understand and follow the policies and procedures of the College and clinical agencies
- f) Understand the consequences of violating the student code of conduct
- g) Understand that posing a direct threat to others is unacceptable and subjects one to discipline
- h) Meet qualifications for licensure by examination as stipulated by the Alabama Board of Nursing
- i) Not to pose a threat to self or others
- j) Function effectively in situations of uncertainty and stress inherent in providing nursing care
- k) Adapt to changing environments and situations
- l) Remain free of chemical dependency
- m) Report promptly to clinicals and remain for 6-12 hours on the clinical unit
- n) Provide nursing care in an appropriate time frame
- o) Accepts responsibility, accountability, and ownership of one's actions
- p) Seek supervision/consultation in a timely manner
- q) Examine and modify one's own behavior when it interferes with nursing care or learning

Note to all applicants: The essential functions form must be signed and dated by the student. This states that you have read and agreed to the terms. You will receive the essential functions form for the nursing program once accepted into the program for a healthcare provider to complete.

Angela Gole
Student's Signature

12/16/21
Date

M. J. Campbell
Physician's Signature

12-16-21
Date



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Gulden

FIRST NAME: Amanda

TSCC ID #: _____

DUG: 2/12/91

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: 4/25/1991

DATE OF MOST RECENT BOOSTER: 12/16/2021

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



INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Gulden FIRST NAME: Amanda TSCC ID #: _____

DOS: 2/12/91

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: 12/16/21 MANUFACTURER: GSK Fluarix LOT #: 7R9NM EXPIRATION DATE: 01/30/22
Quadrivalent

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: [Signature]

NAME OF OFFICE OR FACILITY: Auburn Washburn Health Services PHONE #: 244-3261

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

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: Gulden FIRST NAME: Amanda TSCC ID #: _____

DUG: 2/17/91
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: 12/11/21 POSITIVE? (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE?
DATE OF MUMPS TITER: 12/11/21 POSITIVE? (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE? (≥ 1.1 AI)
DATE OF RUBELLA (MEASLES) TITER: 12/11/21 POSITIVE? (≥ 1.1 AI) NEGATIVE? (≤ 0.7 AI) (please identify results with a ✓)

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

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



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Gulden FIRST NAME: Amanda TSCC ID #: _____

DUG: 2/12/91

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: 12/16/21 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Muranda Fain, RN

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fain

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

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 _____

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



HEALTH EXAMINATION FORM

LAST NAME: Gulden FIRST NAME: Amanda TSCC ID #: _____ PHONE NUMBER: _____

DOB: 2/12/91

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

Allergies (Food/Drug/Latex, etc.)								
PCN								
C O M P L E T E	Height	<u>6'10"</u>	Weight	<u>145.3</u>	BP	<u>128/91</u>	Pulse	<u>83</u>
	Vision Right 20/	<u>20</u>	Left 20/	<u>20</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: _____

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: tx w/ celexa

The student is taking prescribed medications on a regular basis? Yes ☒ No

If yes, please list: celexa 10mg once daily

On the basis of my examination on this day DEC 16, 2021, 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

AUM Student Health Services

Immunization Record

Patient Name: Amanda Gulden

Birthdate: 2/12/91

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B	1/4/02	(Deltoid)					JS
Other							

LOT: [REDACTED]
EXP: [REDACTED]
NDC 0000-021-03
Hepatitis B
Vaccine
(Recombinant)
ENGRIX-B
20 mcg/ml
Mfr. by
GlaxoSmithKline
Biotek

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID							

Initials	Signature	Initials	Signature
JS	[Signature]		

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

STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Amanda Golden
DATE OF BIRTH 2 / 12 / 91
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?	☒	☐	☐

Tdap + Flu

FORM COMPLETED BY Amanda Golden DATE 2/14/21
FORM REVIEWED BY MS RN DATE 1/4/2021

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.