

AUM Student Health Services

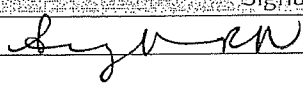
Immunization Record

Patient Name: Candi Doss - Mc LeroyBirthdate: 5/27/76

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	Visit Date	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	1/23/18	1/25/18	0.00 mm Neg	SP	C5471AA	(L) forearm	AM

Initials	Signature	Initials	Signature
AM			

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

STAMP ABOVE

MEDICAL REPORT FOR CHILD PLACING AGENCIES / RESIDENTIAL CHILD CARE FACILITIES

Name Candi Doss-McLeroy Date of Birth 05/27/1974
Address 235 Sherwood Trail, Wetumpka, AL 36093
Employment Agency / Facility Name Brantwood Children's Home
Position Campus Manager

To the Examining Physician:

This examination is needed to determine my physical, psychological, and emotional ability to care for children and perform services in a child placing agency / residential child care facility. I hereby authorize you to furnish a report of my examination to the above-named agency / facility.

Signature _____ Date _____

Tests (Initial TB test to be completed with repeat test every two years if no extenuating circumstances exist)

Date and result of Intradermal Tuberculin Test (Mantoux) 01/25/2018 - Negative (0mm)

If Mantoux was positive, date and result of chest x-ray by RN-BC

Medications Is this person currently taking a medication that will affect alertness, reactions, or driving skills?

☐ No ☐ Yes If "Yes," please describe _____

Physical Limitations Are there any physical limitation that may affect this person's ability to perform duties?

☐ No ☐ Yes If "Yes," please describe _____

Have you observed any psychological or emotional behaviors that will limit this person's ability to care for children?

☐ No ☐ Yes If "Yes," please describe _____

If this person needs a referral to another health professional, please describe in the "Comments" section.

Comments _____

In my opinion, the physical examination reveals that the above-named person is free of any infectious or contagious disease and is physically fit to care for children and perform services in a child placing agency / residential child care facility.

Name of medical doctor, physician's assistant, or certified nurse practitioner completing exam (**Please print**)

Signature _____ Date _____