

**AUM Student Health Services
Immunization Record**

Patient Name: Cheyenne Shaw

Birthdate: 10/21/94

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	1/22/18	1/24/18	0.00mm Neg.	SP	C5471AA	(2) forearm	AM

Initials	Signature	Initials	Signature
AM	<i>[Signature]</i>		

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

STAMP ABOVE

College of
Health & Human
Services

40 Montgomery
Street
Montgomery,
Alabama
36104-

34834-2320

TROY
UNIVERSITY

NOTE: The use of "white-out" or other correction fluid is not acceptable on this form.

VERIFICATION OF ANNUAL PHYSICAL EXAMINATION

I certify that of this date, _____, I have examined
_____ and found this person to be free of
communicable diseases and physically able to carry out nursing functions in a clinical
setting. *Tuberculin skin test within last 12 months 01/24/18
(date)

Results: 0.00 mm (Negative) [Signature] RN - BC

*If TB skin test results were positive, a chest x-ray will be required at the time of admission to clinical nursing courses, and every two years thereafter. If TB skin test results were positive, another TB skin test is not required.

Chest x-ray date: _____

Current Health Problems: _____

Signature

Name of Physician or Qualified RN (i.e. Certified Nurse
Practitioner or Employee Health Nurse)

****PLEASE AFFIX OFFICIAL SEAL OR STAMP****

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Address

NOTE:

The School of Nursing requires that the physical include a tuberculin skin test or chest x-ray. The School of Nursing should be notified if findings represent a hazard to clients with whom the student would come in contact. Providing any false information will be grounds for denial of admission to the program or grounds for dismissal.

