

**AUM Student Health Services
Immunization Record**

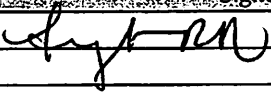
Patient Name: Tricia Hoffman

Birthdate: 5/2

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	Visit Date	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B							
Other							

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given	Date Read	Results	MFR	LOT#	Comments	Initials
	5/29/19	5/31/19	0mm	SP	CSS63AB	(L) forearm	AM

Initials	Signature	Initials	Signature
AM			

STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Tricia Marie Hoffman

DATE OF BIRTH 11 / 19 / 1990
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?	☐	☒	☐

FORM COMPLETED BY Tricia Hoffman TH DATE 5-28-2019

FORM REVIEWED BY _____ DATE _____

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.

EDINBORO UNIVERSITY OF PENNSYLVANIA

The Report of the Health Evaluation MUST be on file with the director of health services at Edinboro University prior to the student's enrollment date.

Return to: Student Health Services

Ghering Health & Wellness Center

320 Scotland Road

Edinboro, PA 16444

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers. This information is strictly for the use of the Health Services and will not be released without student consent.

Student's Name TRICIA HOFFMAN SS# 183-72-5897

IMMUNIZATION DOCUMENTATION

VACCINE	DATES		
DPT- Initial series of 3 injections Required	#1 1/23/91	#2 5/8/91	#3 2/27/92 - 5/11/96
Td (Tetanus-Diphtheria)-Booster within past 10 years	5/27/02	Tdap 6/25/09	
Polio- Series of 3 Doses	#1 1/23/91	#2 5/8/91	#3 2/27/92 - 5/11/96
MMR- 2 Doses	#1 2/27/92	#2 5/11/96	
Hepatitis B 3 Doses	#1 9/10/96	#2 10/11/96	#3 3/7/97
Hepatitis A 2 Doses	#1	#2	
Meningitis Vaccine	06/25/09		
Other			

Last Tuberculin Skin Test- Date 2/27/92 Result N

BP = 1 Height 72 Weight 145 lbs. UNCORRECTED Corrected Vision- Right- 20/20 Left- 20/20

Urinalysis: Sugar (-) Albumin (-) Micro (-)

Hemoglobin (if indicated) N/A

Are there any abnormalities of the following systems? Describe fully. Use additional sheet if necessary.

System	YES	NO
Head, Ears, Nose, Throat		
Respiratory		/
Cardiovascular		/
Gastrointestinal		/
Hernia		/
Eyes		/
Genitourinary		/
Musculoskeletal		/
Metabolic/Endocrine		/
Neuropsychiatric		/
Skin		/

lesion

Is there loss or seriously impaired function of any organ? Yes ☐ No ☒

Have you any general comments?

Recommendations for physical activity (PE, Intramurals, ROTC) Unlimited ☒ Limited ☐ Explain:

Do you have any recommendations regarding care of this student? Yes ☐ No ☒

Is the patient now under treatment for any medical or emotional condition? Yes ☐ No ☒

PHYSICIAN'S SIGNATURE

[Signature]

ADDRESS

1095 Million Dollar Hwy, St Marys PA Phone # 814-781-3310

PRINT LAST NAME

Christa Bonnett

15857

DATE 1-6-10

Edinboro University of Pennsylvania CONFIDENTIAL HEALTH RECORD

Information provided will not be used to influence your situation at the University. It will be used, if necessary solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of the Health Services and will not be released to anyone without your knowledge and consent.

Name: Tricia Marie Hoffman SS# 183-72-5897 Date of Birth 11-19-90 Sex F

Permanent Home Address: 1113 S MICHAEL ST, ST MARYS, PA 15857

In Case of (1) PEGGY/BEN HOFFMAN PARENTS 814-781-1633

Emergency Name Relationship Area Code & Phone #
Notify Address 1113 S MICHAEL ST, ST MARYS, PA 15857

(2) Name DONNA/DICK SIMBECK GRANDPARENTS 814-834-4232

Address 533 N MICHAEL ST ST MARYS, PA 15857

ALLERGIES: Medication/Other - Check or fill in appropriate boxes

☒ Aspirin	☐ Sulfa	☐ Food-	☐ Animals-
☒ Penicillin	☐ Codeine	☐ Pollen	☐ Other-

FAMILY Medical History: If any of your blood relatives had the disease listed, check in the space provided. (include parents, grandparents, and brothers or sisters.)

☐ Alcoholism	☐ Tuberculosis	☐ Stroke	☐ Other (specify)
☐ Anemia	☐ Mental Illness	☒ Diabetes <u>TYPE II</u>	☐ Other
☐ Bleeding Tendency	☐ Migraines	☐ Heart Disease	☐ Other
☐ Cancer	☐ Obesity	☒ High Blood Pressure	☐ None

PERSONAL MEDICAL HISTORY: Have You Had Any of the Following Medical Conditions?

☐ ADD/ADHD	☐ Chronic Bronchitis	☐ Heart Murmur	☐ Phlebitis
☐ Acne	☐ Chronic Inflammatory Bowel Dis	☐ Hepatitis	☐ Pregnancy
☐ Alcohol or Drug Problem	☐ Chronic Tonsillitis	☐ Hypertension (High BP)	☐ Prostatitis
☐ Anemia	☐ Colds (frequent)	☐ Mononucleosis	☐ Rheumatic Fever
☐ Anorexia Nervosa	☐ Crohn's Disease	☐ Insomnia	☐ Rheumatoid Arthritis
☐ Anxiety	☐ Depression	☐ Joint/Bone Disease	☐ Scarlet Fever
☐ Arthritis	☐ Dermatology Problems	☒ Joint/Bone Injury <u>Wrist</u>	☐ Seizure Disorder/Epilepsy
☐ Asthma	☐ Diabetes	☐ Kidney Infection <u>2005</u>	☐ Sinusitis
☐ Back Problems	☐ Diarrhea (Recurrent)	☐ Kidney Stones	☐ Sexually Transmitted Dis
☐ Binge Eating	☐ Digestive Troubles	☐ Menstrual Cramps	☐ Systemic Lupus Erythematosus
☐ Bladder Infection	☐ Dizziness/Fainting	☐ Menstrual Disorders	☐ Thyroid Disease
☐ Bleeding Trait	☐ Ear Problems	☐ Migraine	☐ Ulcerative colitis
☐ Blood Clots	☐ Eye Problems	☐ Multiple Sclerosis	☐ Worry/Nervousness
☐ Blood Disorders	☐ Hay fever/Allergies	☐ Muscular Dystrophy	☐ HIV/AIDS
☐ Bulimia	☐ Headaches (Recurrent)	☐ Obesity	☐ Other-Specify
☐ Cancer/Malignancy	☐ Head Injury	☐ Pelvic Infection	☐ Surgeries-Specify
☐ Cerebral palsy	☐ Heart Condition	☐ Peptic Ulcer	

DISABILITY- Do you consider yourself handicapped or disabled in any way that requires you to receive special consideration from the University? If so please check the appropriate box and give specifics.

☐ Vision	☐ Other Motor	☐ Other- Specify
☐ Hearing	☐ Emotional	
☐ Mobility	☐ Learning	

Please explain your disability:

List any medication you are currently taking on a regular basis: None

List any condition currently under treatment: No

Tricia Hoffman

00041170

Florida International University Immunization Documentation Form

Name: HOFFMAN TRICIA MARIE
Last First Middle

Panther ID Number: 4821230 Birth Date: 11 / 19 / 1990

SECTIONS: A, B, & C TO BE COMPLETED BY AUTHORIZED MEDICAL PERSONNEL ONLY

A. MMR Combined (Measles, Mumps, and Rubella): Two doses fulfill requirements

2 / 27 / 92 1st dose (received after 12 months of age or later).
Month Day Year
5 / 11 / 96 2nd dose (received at 28 days or more after 1st dose). or
Month Day Year

Measles (Rubeola): Two doses required

____ / ____ / ____ 1st dose (received after 12 months of age in 1969 or later).
Month Day Year
 ____ / ____ / ____ 2nd dose (received at 28 days or more after the 1st dose).
Month Day Year or
 ____ / ____ / ____ Positive Blood Titer (Lab results **must** be attached).
Month Day Year

-----AND-----

Rubella (German Measles): One dose required

____ / ____ / ____ 1st dose (received after 12 months of age and in 1969 or later).
Month Day Year or
 ____ / ____ / ____ Positive Blood Titer (Lab results **must** be attached).
Month Day Year

B. Hepatitis B: Three doses fulfill requirements

9 / 10 / 96 1st dose Tdap 4/25/09
Month Day Year
10 / 11 / 96 2nd dose (must be at least 28 days after the 1st dose).
Month Day Year
3 / 7 / 97 3rd dose (must be at least 112 days after the 1st dose
Month Day Year and 56 days after the 2nd dose).
 ____ / ____ / ____ Positive Blood Titer (Lab results **must** be attached).
Month Day Year or

C. Meningitis: One dose required

11 / 25 / 09
Month Day Year

Emily Hanes office Assistant
 Health Care Provider Signature/Credentials

5/14/13
 Date

**Health Care Provider
Office Stamp Required:**

ERPG
 Keystone Medical Assoc.
 1095 Million Dollar Highway
 St. Mari, AZ 8557

Please submit this completed form at least four weeks prior to registration to:

Florida International University, University Health Services

Modesto Maidique Campus
 UHSC-Room 101
 11200 S.W. 8 Street
 Miami, FL 33199
 305-348-3336(FAX)
 305-348-2401

or

Biscayne Bay Campus
 Health Care Center
 3000 N.E. 151 Street
 North Miami, FL 33181
 305-919-5312(FAX)
 305-919-5675
 1/29/2010