



TUBERCULOSIS (TB) SKIN TEST

LAST NAME: King FIRST NAME: Benesia 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: m. Richman, RN

DATE ADMINISTERED (TEST #1): 7/12/2021 LOT #: 65736AA

EXPIRATION DATE: 8/17/2021
left forearm

DATE READ: _____ (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 1 RESULTS: _____ POSITIVE ☒ NEGATIVE _____ REDNESS (please identify results with a ✓)
_____ mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE J. B. Smith, CRNP

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: _____

DATE ADMINISTERED (TEST #2): _____ LOT #: _____

EXPIRATION DATE: _____

DATE READ: _____ (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 2 RESULTS: _____ POSITIVE _____ NEGATIVE _____ REDNESS (please identify results with a ✓)
_____ mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
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:

- 1) Your provider will likely order a chest x-ray and you will provide the program with a Radiologist's report - OR
- 2) Your provider (on provider letterhead) can document that you are free from TB and do not need a 2-step TB test or chest x-ray



HEPATITIS B IMMUNIZATION

LAST NAME: King FIRST NAME: Benedicta TSCC ID #: _____

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: 7/26/21 POSITIVE? _____ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? ☒ (anti-HBs ≤ 10 mIU/mL) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS, PLEASE PRINT: Lindsey Barton, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

L. Barton, CRNP

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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: _____

PHYSICIAN/NURSE PRACTITIONER 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 ≥ 10 mIU/mL) NEGATIVE? _____ (anti-HBs ≤ 10 mIU/mL) (please identify results with a $\checkmark$)



HEALTH EXAMINATION FORM

LAST NAME: King FIRST NAME: Renesia TSCC ID #: _____ PHONE NUMBER: _____

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

Allergies (Food/Drug/Latex, etc.)			
C O M P L E T E	Height	<u>63</u>	Weight <u>187.5</u>
	BP	<u>127/92</u>	Pulse <u>80</u>
	Vision Right 20:	<u>25</u>	Left 20: <u>20</u>
	Corrected:	Y ☐ N ☒	
		NORMAL	ABNORMAL FINDINGS
	CBC	☒	
	Cardiovascular	☒	
	Pulses	☒	
	Heart	☒	
	Lungs	☒	
Skin	☒		
E.N.T.	☒		
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: HTN

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: Lisinopril 20mg QD, Amlodipine 5mg QD

On the basis of my examination on this day 7/28/2021, 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)

Lindsey Barton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

L. Barton, CNP

Provider:

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MONTGOMERY, AL 36124-4023



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Liny

FIRST NAME: Benesia

TSCC ID #: _____

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: 7/28/2011 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Lindsey Burton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider:
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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 _____

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MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: King

FIRST NAME: Brenda

TSCC ID #: _____

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: 7/28/01 POSITIVE? ✓ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)
DATE OF MUMPS TITER: 7/28/01 POSITIVE? ✓ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)
DATE OF RUBELLA (MEASLES) TITER: 7/28/01 POSITIVE? ✓ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.7 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Lindsey Barton, CNP

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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 _____

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TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: King FIRST NAME: Bensia TSCC ID #: _____

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: 7/28/2021 DATE OF MOST RECENT BOOSTER: _____

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Lindsey Burton, LNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

[Handwritten Signature]

Provider:
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LOT:
EXP:

NDC 58160-942-43

Tetanus Toxoid,
Reduced Diphtheria
Toxoid and Acellular Pertussis
Vaccine, Adsorbed
BOOSTRIX

0.5 mL

Mfg. by
GlaxoSmithKline
Biologics

436018

@he told

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