

**AUM Student Health Services
Immunization Record**

Patient Name: Andre Cavichione

Birthdate: 3-29-1999

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B							
Other							

	Date Given:	Date Read:	Results:	MFR	LOT#	CFA Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	8/12/2014	8/12/2014	0mm	Sumofi	69750AA	exp. 8/22/22	JUR

Initials	Signature	Initials	Signature
JUR	JURICHU, RN		

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

STAMP ABOVE

Return
8/12 1pm



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Andre' F. Carichione

Date of Birth: 03/29/1999

Student Number: 00394059

Please mark "yes" or "no" to the following questions.

YES NO

1. Do you have a cough that has lasted longer than 3 weeks?		\
2. Have you coughed up blood or mucus?		\
3. Have you had fever, chills, or night sweats?		\
4. Have you had unintentional weight loss?		\
5. Have you been feeling very tired?		\
6. Have you lost your appetite?		\
7. Have you ever had a positive TB skin test result or Positive interferon gamma release assay (IGRA) result? If so, when?		\
8. Have you ever had an abnormal chest x-ray?		\
9. Have you recently had the mucus coughed up tested for TB?		\
10. Have you ever been told you had TB or latent TB?		\
11. Have you ever taken medicine for TB?		\
12. Have you ever lived with or had close contact with someone who had TB?		\
13. Do you currently have a rash on either forearm?		\
14. Are you immunocompromised? (Steroids, chemotherapy, or other?)		\
15. Have you received a live vaccine in the past 30 days?		\

All TB skin test and Chest x-rays must be performed in the U.S. to be valid.

I attest the above is true and accurate to the best of my knowledge.

Patient Signature: Andre' F. Carichione

Date: 08/10/21

Provider Signature: [Signature]

Date: 8/10/2021