



7/7/02

HEALTH EXAMINATION FORM

LAST NAME: Rayborn FIRST NAME: Riley 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>5'5</u>	Weight	<u>160</u>	BP	<u>113/72</u>	Pulse	<u>68</u>
	Vision Right 20/	<u>13</u>	Left 20/	<u>15</u>	Corrected:	Y ☐ N ☒		

The student has been diagnosed with a chronic/serious medical condition(s)? (Ex. Diabetes, hypertension, seizure disorders, etc.?) _____ Yes ☒ No

If yes, please list: _____

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: ADD, depression

The student is taking prescribed medications on a regular basis? ☒ Yes _____ No

If yes, please list: Strattera 10mg QD

On the basis of my examination on this day July 15, 2022 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 [Signature]

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

**AUM Student Health Services
Immunization Record**

Patient Name: Riley Rayborne

Birthdate: 7/7/2002

Allergies/Medical Alert: PCN, cephalosporins, sulfa

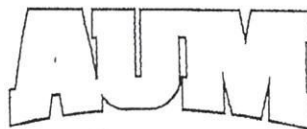
Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B							
Other							

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	7/15/2022	7/18/22	0mm	Sanofi	CS805AA	exp 3/17/23 CFA	MB
	8/2/2022	8/4/2022	0mm	Sanofi	CS805AA	exp 3/17/23 CFA	MB

Initials	Signature	Initials	Signature
MB	Dorinda Mayhew		

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STAMP ABOVE



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Riley Rayborn

Date of Birth: 7/7/02

Student Number:

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

YES NO

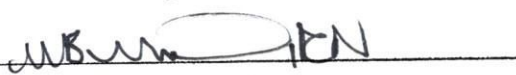
1. Do you have a cough that has lasted longer than 3 weeks?		no
2. Have you coughed up blood or mucus?		no
3. Have you had fever, chills, or night sweats?		no
4. Have you had unintentional weight loss?		no
5. Have you been feeling very tired?		no
6. Have you lost your appetite?		no
7. Have you ever had a positive TB skin test result or Positive interferon gamma release assay (IGRA) result? If so, when?		no
8. Have you ever had an abnormal chest x-ray?		no
9. Have you recently had the mucus coughed up tested for TB?		no
10. Have you ever been told you had TB or latent TB?		no
11. Have you ever taken medicine for TB?		no
12. Have you ever lived with or had close contact with someone who had TB?		no
13. Do you currently have a rash on either forearm?		no
14. Are you immunocompromised? (Steroids, chemotherapy, or other?)		no
15. Have you received a live vaccine in the past 30 days?		no

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: 

Date: 7/15/22

Provider Signature: 

Date: 7/15/2022



7/7/02

INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Rayborn

FIRST NAME: Riley

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: Miranda Bicknell RN

DATE ADMINISTERED (TEST #1): 7/15/2022 LOT #: CS805AA

EXPIRATION DATE: 3/17/2023

DATE READ: 7-18-22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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: Miranda Bicknell RN

DATE ADMINISTERED (TEST #2): 8/12/22 LOT #: CS805AA

EXPIRATION DATE: 3/17/23

DATE READ: 8/14/22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider:
Please place office stamp
here (if possible) for
validation purposes.

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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



7/7/02

HEPATITIS B IMMUNIZATION

LAST NAME: Rayborn FIRST NAME: Riley TSCC ID #: _____

HAVE YOU COMPLETED A SERIES OF HEPATITIS B IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

HEPATITIS B TITER - TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER.

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: 7/19/02 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, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



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: _____

Provider:
Please place office stamp
here (if possible) for
validation purposes.

2ND VACCINATION DATE: _____
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
Please place office stamp
here (if possible) for
validation purposes.

3RD VACCINATION DATE: _____
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
Please place office stamp
here (if possible) for
validation purposes.

AFTER COMPLETION OF THE FULL 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B ANTIBODY TO DOCUMENT IMMUNITY:

DATE OF TITER: _____ 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) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



7/7/02

VARICELLA (CHICKEN POX) IMMUNIZATIONLAST NAME: RaybornFIRST NAME: Riley

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: 7/19/2022 POSITIVE? ☐ (≥ 1.1 AI) NEGATIVE? ☒ (≤ 0.8 AI) (please identify results with a $\checkmark$)PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Lindsey Barton, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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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 OR BOOSTER IS REQUIRED. A HEALTHCARE PROVIDER MAY RECOMMEND A BOOSTER. IF A BOOSTER IS PERFORMED COMPLETE VACCINATION #1 ONLY.

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 _____

Provider:
Please place office stamp
here (if possible) for
validation purposes.

AFTER COMPLETION OF 2-PART SERIES OR BOOSTER, HAVE A TITER DRAWN FOR VARICELLA ANTIBODY TO DOCUMENT IMMUNITY:DATE OF TITER: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



7/7/02

MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATIONLAST NAME: RainbornFIRST NAME: Riley

TSCC ID #: _____

MEASLES/MUMPS/RUBELLA (MMR) TITER - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

HAVE YOU RECEIVED YOUR MMR IMMUNIZATION IN THE PAST? 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-VACCINATION IS REQUIRED.DATE OF MEASLES (RUBEOLA) TITER: 7/5/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)DATE OF MUMPS TITER: 7/5/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)DATE OF RUBELLA (MEASLES) TITER: 7/5/22 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 _____

[Signature]
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MONTGOMERY, AL 36124-4023

IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!
 IF TITER RESULTS ARE NEGATIVE OR IF YOU HAVE NEVER BEEN VACCINATED - 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. A HEALTHCARE PROVIDER MAY RECOMMEND A BOOSTER. IF A BOOSTER IS PERFORMED COMPLETE DOSE #1 LINE ITEM.

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 _____

Provider:
 Please place office stamp
 here (if possible) for
 validation purposes.

AFTER COMPLETION OF STEP 2 (2-DOSE SERIES) OR BOOSTER, HAVE A TITER DRAWN FOR EACH VACCINATION RECEIVED IN STEP 2 TO DOCUMENT IMMUNITY:

DATE OF MEASLES TITER: _____ POSITIVE? _____ NEGATIVE? _____ (please identify results with a ✓)

DATE OF MUMPS TITER: _____ POSITIVE? _____ NEGATIVE? _____ (please identify results with a ✓)

DATE OF RUBELLA TITER: _____ POSITIVE? _____ NEGATIVE? _____ (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



7/7/02

TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Rayborn

FIRST NAME: Riley

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: 9/10/2002
DTap

DATE OF MOST RECENT BOOSTER: 7/19/2014

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

[Handwritten Signature]

Provider:
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