



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Folks-Simmons FIRST NAME: Keira TSCC ID #: A02121395

TUBERCULIN (TB) 2 STEP MANTOUX SKIN TEST - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

STEP 1 - TEST #1:

NAME OF PERSON ADMINISTERING: Rubin Blackwell, CNP

DATE ADMINISTERED (TEST #1): 10/31/2022

LOT #: C5805AA

EXPIRATION DATE: 3/17/23

DATE READ: 11/2/22 (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 Rubin Blackwell, CNP

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): 11/7/2022

LOT #: C5805AA

EXPIRATION DATE: 3/17/2023

DATE READ: 11/9/22 (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 Rosie Blackwell, CNP

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-0023

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

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



HEALTH EXAMINATION FORM

LAST NAME: FOLKS-SIMMONS FIRST NAME: KEIRA TSCC ID #: A02121395 PHONE NUMBER: 3346493249

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

Allergies (Food/Drug/Latex, etc.) <u>NKA</u>				
C O M P L E T E	Height <u>5'0"</u>	Weight <u>183.3</u>	BP <u>108/58</u>	Pulse <u>66</u>
	Vision Right 20/ <u>25</u>	Left 20/ <u>15</u>	Corrected: ☒ Yes ☐ No	
		NORMAL	ABNORMAL FINDINGS	
	CBC		☒ Pending Anemia workup	
	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: _____

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: _____

On the basis of my examination on this day 10-31-2022, 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) Robin Blackwell CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CNP

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HEPATITIS B IMMUNIZATION

LAST NAME: FOLKS Simmons

FIRST NAME: KEIRA

TSCC ID #: A02121395

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: 10/31/2022 POSITIVE? ☒ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? ☐ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Robin Blockwell, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blockwell 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 THE FULL 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B ANTIBODY TO DOCUMENT IMMUNITY:

DATE OF TITER: _____ POSITIVE? ☐ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? ☐ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: FOLKS-SIMMONS

FIRST NAME: KEIRA

TSCC ID #: A02121395

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: 10/31/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Robin Blackwell, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell 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 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 _____

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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 _____



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Folks-Simmons

FIRST NAME: Keira

TSCC ID #: A02121395

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: 10/31/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)

DATE OF MUMPS TITER: 10/31/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)

DATE OF RUBELLA (MEASLES) TITER: 10/31/22 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Robin Blackwell, NP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell, NP

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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 _____

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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 _____



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: FOLKS-SIMMONS

FIRST NAME: KEIRA

TSCC ID #: A021213915
MON/18

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: 8/22/00

DATE OF MOST RECENT BOOSTER: 2/21/2019

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Robin Blackwell, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell, CNP

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Auburn Montgomery Student Health Services
7461 East Dr
Montgomery, AL 36117
(334) 244-3281

Laboratory Results

Patient Name: KEIRA FOLKS-SIMMONS			Order Date: 10/31/2022
MRN: 4982	DOB: 06/10/2000	Phone: () -	Gender:
Placer Order ID: 00835463		Physician: BLACKWELL	
Filler Order ID: AL279029X		Physician ID: 1295276632	
Specimen Date: 10/31/2022 11:06 AM		Fasting:	
Result Date: 11/01/2022 4:07 PM		Disposition:	
Specimen Source: SOURCE, UNSPECIFIED			

MMR (IGG) PANEL		5259	STATUS: F			
Test Name	Abnormal	Result Value	Unit of Measure	Ref Range	Status	Producer ID
MEASLES AB (IGG), IMMUNE STATUS						
197.00			AU/mL		F	AT
AU/mL	Interpretation					
-----	-----					
<13.50	Not consistent with immunity					
13.10-16.49	Equivocal					
>16.49	Consistent with immunity					
The presence of measles IgG suggests immunization or past or current infection with measles virus.						
For additional information, please refer to http://education.QuestDiagnostics.com/fag/FAQ162 (This link is being provided for informational/educational purposes only.)						
MUMPS VIRUS AB (IGG), IMMUNE STATUS						
17.10			AU/mL		F	AT
AU/mL	Interpretation					
-----	-----					
<9.00	Not consistent with immunity					
9.00-10.99	Equivocal					
>10.99	Consistent with immunity					
The presence of mumps IgG antibody suggests immunization or past or current infection with mumps virus.						
RUBELLA AB (IGG), IMMUNE STATUS						
3.55			Index		F	AT
Index	Interpretation					
-----	-----					
<0.90	Not consistent with immunity					
0.90-0.99	Equivocal					
> or = 1.00	Consistent with immunity					
The presence of rubella IgG antibody suggests immunization or past or current infection with rubella virus.						

CBC (DIFF/PLT)				6399	STATUS: F	
Test Name	Abnormal	Result Value	Unit of Measure	Ref Range	Status	Producer ID
WHITE BLOOD CELL COUNT		4.5	Thousand/uL	3.8-10.8	F	AT
RED BLOOD CELL COUNT	H	5.14	Million/uL	4.20-5.10	F	AT

Confidential

ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: FOLKS, KEIRA BRANDI-JDAZA
 DOB: 06/10/2000
 Chart #:
 Date of Service: 10/31/2022

Vaccine Family	Type of Vaccine (no Brand Name)	Date Given (mm/dd/yy)	Age at Adm	Dose (cc/mL)	Route & Site	Mfr.	Lot #	VIS Date	Vaccinator Signature
Tetanus, Diphtheria, (Pertussis) (e.g., Td, Tdap)	DTAP	08/22/00	2 m	0.5					
	DTAP	10/13/00	4 m	0.5					
	DTAP	11/08/00	4 m	0.5					
	DTAP	12/14/00	6 m	0.5					
	DTAP	06/12/03	3 y	0.5					
	DTAP	07/01/04	4 y	0.5					
	TDAP	04/17/13	12 y	0.5	PO LD	PMC	C4030AA		OUTSIDE CLINIC
Hepatitis A (e.g., HepA, HepA-HepB)									
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PED	06/12/00	0 m	0.5					OUTSIDE CLINIC
	HEP B ADOL/PED	07/18/00	1 m	0.5					
	HEP B ADOL/PED	12/14/00	6 m	0.5					
Human Papillomavirus (e.g., HPV)									
Measles, Mumps, Rubella (MMR, MMRV)	MMR	06/12/03	3 y	0.5					
	MMR	07/01/04	4 y	0.5					
Meningococcal (MCV4, MPSV4)	MCV4P (MENACTRA)	04/17/13	12 y	0.5	PO LD	PMC	U4397AB		OUTSIDE CLINIC
Pneumococcal (e.g. PCV, PPV)	PCV7	03/07/01	8 m	0.5					
	PCV7	06/11/01	12 m	0.5					
Polio (e.g., IPV, DTaP-HepB-Hib)	IPV	08/22/00	2 m	0.5					
	IPV	10/13/00	4 m	0.5					
	IPV	11/08/00	4 m	0.5					
	IPV	06/12/03	3 y	0.5					
	IPV	07/01/04	4 y	0.5					
Varicella (Var, MMRV)	VARICELLA	06/11/01	12 m	0.5					
	VARICELLA	06/14/10	10 y	0.5					
Influenza (e.g., TIV, LAIV)									
Zoster									
Other	HIB (PRP-OMP)	08/22/00	2 m						
	HIB (PRP-OMP)	10/13/00	4 m						
	HIB (PRP-OMP)	12/14/00	6 m						
	HIB (HBOC)	06/12/03	3 y						

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 RM 102 MOORE HALL
 MONTGOMERY, AL36117
 334 2443281

PPD	Date	Results	PPD	Date	Results
Mantoux			Maxtoux		
Mantoux			Mantoux		
Mantoux			Mantoux		

VACCINE ADMINISTRATION RECORD**(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)**

This document complies with Article 36 and Annex 6 of the World Health Organization International Health Regulations (IHR) of 2005. International Health Regulations call for this document to be accepted in lieu of the International Certificate of Vaccination (PHS Form 731) when traveling outside the United States. In accordance with the IHR, this automated record is an equivalent document issued by the United States Armed Forces.

By inserting the Vaccine Information Statement (VIS) version date in the applicable field, providers verify that the vaccine(s) annotated were administered and current VISs were given to the parent, legal guardian or patient. This form complies with federal record-keeping requirements of the National Childhood Vaccine Injury Act of 1986 as amended 14 December 1993. Parent, guardian, or patient signature is not required unless state law mandates a guardian signature and proof of informed consent.

Vaccine (Series)	Date	Manufacturer	Lot Number	Dosage	VIS Version	Administering Tech
Adenovirus types 4 and 7	18 Mar 2019	Barr Laboratories	34600399	2 tablets	6/11/14	ACHA, CHERRY
COVID-19 Pfizer(1)	1 Oct 2021	Pfizer, Inc	30130BA			TRANSCRIBED
COVID-19 Pfizer(1)	22 Oct 2021	Pfizer, Inc	30130BA			TRANSCRIBED
Hep A-Hep B(1)	18 Mar 2019	GlaxoSmithKline	3C422	1.0 mL	07/20/16	ACHA, CHERRY
Hep A-Hep B(2)	18 Apr 2019	GlaxoSmithKline	H4A37	1.0 mL	07/20/16	KUEHN, SHANE
Hep A-Hep B(3)	2 Aug 2020	GlaxoSmithKline	75C72	1.0 mL	7/20/2016	JOHNSON, KEISHA
Influenza, injectable, quadrivalent	21 Feb 2019	Seqirus	YF44009	0.5 mL		
Influenza, injectable, quadrivalent, pres	6 Nov 2020	Seqirus	P100261246	0.5 mL	08/14/2019	WHITING, ALBERT
Influenza, injectable, quadrivalent, pres	4 Dec 2021	GlaxoSmithKline	334RL	0.5 mL		JOHNSON, KEISHA
IPV(1)	21 Feb 2019	Sanofi Pasteur	P1A432M	0.5 mL	7/20/16	
Meningococcal MCV4P	21 Feb 2019	Sanofi Pasteur	u6002CA	0.5 mL	08/24/2018	
Tdap	21 Feb 2019	GlaxoSmithKline	429H5	0.5 mL	02/24/2015	

Immunization Exemptions

Vaccine	Exemption	Expiration Date
Measles	Pos Titer	Indefinite
Mumps	Pos Titer	Indefinite
Rubella	Pos Titer	Indefinite
Varicella	Pos Titer	Indefinite

LAST ITEM**DO NOT MAKE ENTRIES BELOW THIS BLOCK**

	Name: FOLKS SIMMONS KEIRA B		Sex: F
	Status: NG		Rank: SRA
	Service: Air Force	Sponsor's ID: 1543985801	DOB: 10 Jun 2000

ADULT IMMUNIZATION RECORD

Allergies:
Reactions:

Name: FOLKSSIMMONS, KEIRA
 DOB: 06/10/2000
 Chart #: _____
 Date of Service: 10/31/2022

Vaccine Family	Type of Vaccine (no Brand Name)	Date Given (mm/dd/yy)	Age at Adm	Dose (cc/mL)	Route & Site	Mfr.	Lot #	VIS Date	Vaccinator Signature
Tetanus, Diptheria, (Pertussis) (e.g., Td, Tdap)									
Hepatitis A (e.g., HepA, HepA-HepB)									
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)									
Human Papillomavirus (e.g., HPV)									
Measles, Mumps, Rubella (MMR, MMRV)									
Meningococcal (MCV4, MPSV4)									
Pneumococcal (e.g. PCV, PPV)									
Polio (e.g., IPV, DTaP-HepB-Hib)									
Varicella (Var, MMRV)									
Influenza (e.g., TIV, LAIV)									
Zoster									
Other	Pfizer Covid19	10/01/21	21 y		IM	PFR	30130BA		OUTSIDE CLINIC
	Pfizer Covid19	10/22/21	21 y		IM	PFR	30130BA		OUTSIDE CLINIC

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PPD	Date	Results	PPD	Date	Results
Mantoux			Maxtoux		
Mantoux			Mantoux		
Mantoux			Mantoux		