

**AUM Student Health Services
Immunization Record**

Patient Name: Jordan Fain

Birthdate: 8/17/85

Allergies/Medical Alert: NKDA

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	7/1/25	7/13/25	0mm	SP	3CA43C3	Lt. FA	LB

Initials	Signature	Initials	Signature
		LB	J. Fain, CAP

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

STAMP ABOVE



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Justin Fan

Date of Birth: 8/17/1985

Student Number: N/A

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: _____

Date: 7/1/25

Provider Signature: J. P. [Signature]

Date: 7/1/25