

IMMUNIZATION/TITER HISTORY

Primm Daveenyah Aleccc 03/12/2000
LAST NAME FIRST NAME MIDDLE BIRTH DATE

All CHS students must complete an immunization/titer history before enrolling in classes. Please refer to your program/school Student Handbook for specific information on immunization requirements.

MMR (Measles, Mumps, and Rubella)

If born before 1957, no MMR immunizations are required

Combined Vaccines (Two doses at least one month apart)

MMR	#1 <u>06/04/2001</u> month/day/year	#2 <u>03/17/2004</u> month/day/year
-----	---	---

OR

Laboratory Evidence of Immunity

Measles	<u> </u> / <u> </u> / <u> </u> month/day/year	☐ Immune ☐ Non-Immune
Mumps	<u> </u> / <u> </u> / <u> </u> month/day/year	☐ Immune ☐ Non-Immune
Rubella	<u> </u> / <u> </u> / <u> </u> month/day/year	☐ Immune ☐ Non-Immune

*If not immune, complete vaccination series

Tdap (tetanus-diphtheria-acellular pertussis)

One dose administered within the last 10 years. Other Tetanus vaccine types are NOT acceptable.

12/07/2020
month/day/year

Varicella (Chickenpox)

History of Disease

08/13/2001
month/day/year

(A minimum of the
Month/Year REQUIRED)

OR

Vaccines

#1 <u>12/07/2020</u> month/day/year	#2 <u> </u> / <u> </u> / <u> </u> month/day/year
---	---

OR

Laboratory Evidence of Immunity

<u> </u> / <u> </u> / <u> </u> month/day/year
☐ Immune ☐ Non-Immune

*If not immune, complete vaccination series

Hepatitis B*

Vaccines

	One month after dose 1	Five months after dose 2
#1 <u>03/15/00</u> month/day/year	#2 <u>04/28/00</u> month/day/year	#3 <u>06/15/00</u> month/day/year

OR

<u> </u> / <u> </u> / <u> </u> month/day/year	*This must be a <u>Hepatitis B Surface Antibody Titer</u> that indicates you are IMMUNE to Hepatitis B.
☐ Immune ☐ Non-Immune	

*If not immune, complete vaccination series

Comments: 4th dose on 09/14/2000

Form must be completed by one of the following licensed healthcare providers: MD, DO, NP/CRNP, PA, RN, LPN, or Pharmacist. The form must be dated **NO EARLIER THAN** the last listed vaccination or lab test for the form to be valid. Nothing should be added to form after the healthcare provider signs and dates **UNLESS** the individual addition is signed, credentialed, and dated.

Licensed Healthcare Provider's Printed Name and Credentials: Maranda Fain, CRNP

Facility Name: Auburn University Montgomery / Warhawk Health Services

Facility Address: 7401 East Dr. Suite 102

City: Montgomery

State: AL

Zip: 36117

SIGNATURE OF PROVIDER: M. Fain, CRNP

DATE: 6/8/22

TUBERCULOSIS TESTING

Primm Daveenya dleece 03/12/2000
LAST NAME FIRST NAME MIDDLE BIRTH DATE

All schools in the College of Health Sciences require tuberculosis (TB) screening prior to enrollment in courses, requirements vary by school and/or program. Please refer to your school/program's student handbook for specific requirements regarding tuberculosis (TB) screening requirements. Only this form will be accepted to meet program/school requirements. If you have received a BCG vaccine, an IGRA test is preferred. If you have a history of a positive TB skin test (≥ 10 mm) or IGRA, please supply information regarding any evaluation and/or treatment below. Guidelines are based upon the recommendation of the CDC and the American College Health Association.

***Skin tests *MUST* be read 48-72 hours after they are placed.

***The second test in a two-step TB test *MUST* be administered between one (1) and three (3) weeks after the first test was read.

Section A	Test Type	Date Placed/Ordered	Date Read/Resulted	Results
No history of positive TB tests.	Skin Test #1	<u>06/08/2022</u>	<u>06/10/2022</u>	<u>0</u> mm
	Skin Test #2	<u>06/15/2022</u>	<u>06/17/2022</u>	<u>0</u> mm
Skin Test <u>OR</u> Blood Test Required	IGRA Blood Test	____/____/____	____/____/____	____ Negative ____ Positive
	☐ T-spot	____/____/____	____/____/____	
	☐ Quantiferon Gold	____/____/____	____/____/____	
	Chest X-ray	____/____/____	____/____/____	____ Negative ____ Positive

OR

Section B	Positive Test Type	Date Placed/Ordered	Date Read/Resulted	Results
History of Latent Tuberculosis, Positive Skin Test, or Positive Blood Test	Positive Skin Test	____/____/____	____/____/____	____ mm
	Positive IGRA Blood Test	____/____/____	____/____/____	
Chest X-Ray Required	☐ T-spot	____/____/____	____/____/____	
	☐ Quantiferon Gold	____/____/____	____/____/____	
	Chest X-ray	____/____/____	____/____/____	____ Negative ____ Positive
	Prophylactic medications for latent TB taken?	☐ Yes ☐ No		
	Total duration of prophylaxis?	____ months		
	Date of last annual TB symptom questionnaire (if applicable)	____/____/____		☐ Attach copy

OR

Section C		Date	Results
History of Active Tuberculosis	Date of Diagnosis	____/____/____	☐ Attach copy
	Date Treatment Completed	____/____/____	☐ Attach copy
History of Treatment Required	Date of last annual TB symptom questionnaire (if applicable)	____/____/____	☐ Attach copy
	Date of last Chest X-ray	____/____/____	____ Negative ____ Positive ☐ Attach copy

*This form must be completed by one of the following licensed healthcare providers: MD, DO, NP/CRNP, PA, RN, or LPN. The form must be dated **NO EARLIER THAN** the last listed test date on the form to be valid. Nothing should be added to form after the healthcare provider signs and dates **UNLESS** the individual addition is signed, credentialed, and dated.*

Licensed Healthcare Provider's Printed Name and Credentials: Maranda Fain, CRNP

Facility Name: Auburn University Montgomery / Warhawk Health Services

Facility Address: 7401 East Drive Suite 102

City: Montgomery

State: AL

Zip: 36117

SIGNATURE OF PROVIDER: M. Fain CRNP

DATE: 6-8-22

PHYSICAL EXAMINATION

Pimm Daveenyah Aleece 03/12/2000 SEX: M ☐ F ☒
LAST NAME FIRST NAME MIDDLE BIRTH DATE

All CHS students must submit a completed physical examination on this form prior to enrolling in courses. Please refer to your program/school handbook for further information on specific requirements.

Blood Pressure 112/74 Pulse 73 Height 64.5 in Weight 184.7 lbs. Vision 20/25 ^{corrected} right 20/15 left

The College of Health Sciences (CHS) requires that all students have evidence of a physical examination from a physician, physician assistant, or nurse practitioner verifying that the individual is able to meet physical and mental requirements – with or without accommodation – for both didactic and clinical components of their respective program. The physical examination must be completed and this form submitted before the first day of class. The student affirms that by submitting this form he or she consents to the disclosure of the information contained herein to the program, school and college's administrators, faculty and staff, as well as experiential site preceptors/coordinators as is necessary to ensure compliance with program requirements and affiliated site requirements. Some programs may require an annual physical examination.

REVIEW OF SYSTEMS:

Are there abnormalities in the following systems? Describe fully, including any assistive devices which may be required (e.g. hearing aids, eyeglasses, prosthetics, etc.).

	NO	YES	Comments
HEENT	☒	☐	
Respiratory	☒	☐	
Cardiovascular	☒	☐	
Gastrointestinal	☒	☐	
Musculoskeletal	☒	☐	
Neurologic	☒	☐	
Dermatologic	☒	☐	

ALLERGIES: tomatoes

- Is the patient now under treatment for any medical or psychological condition? NO ☒ YES _____ (explain) _____
- Does this patient have any active prescriptions, even if for occasional use only? NO ☒ YES _____ (list) _____
- Has this patient ever been diagnosed with alcoholism or another drug dependency (not including tobacco)? NO ☒ YES _____ (list) _____
- Are there any conditions, physical and /or psychological, which may interfere with functioning as a health professional student in the classroom or clinical setting? NO ☒ YES _____ (please comment) _____

NOTES/COMMENTS: _____

Form must be completed by one of the following licensed healthcare providers: MD, DO, NP/CRNP, or PA. Nothing should be added to form after the healthcare provider signs and dates UNLESS the individual addition is signed, credentialed, and dated.

Licensed Healthcare Provider's Printed Name and Credentials: Maranda Fain, CNP
Facility Name: Aum Warhawk Health Services
Facility Address: 7401 East Dr. Suite 102
City: Montgomery State: AL Zip: 36117
SIGNATURE OF PROVIDER: M. Fain, CNP DATE: 6-8-22