



HEALTH EXAMINATION FORM

LAST NAME: Gauke FIRST NAME: Anastasia TSCC ID #: _____ PHONE NUMBER: _____

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

Allergies (Food/Drug/Latex, etc.) <u>NKDA</u>								
C O M P L E T E	Height	<u>5'6"</u>	Weight	<u>175 lbs.</u>	BP	<u>121/71</u>	Pulse	<u>75</u>
	Vision Right 20/	<u>20</u>	Left 20/	<u>20</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: _____

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 1-4-22, 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) MARANDA FUIN, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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

H. Councill Trenholm State Community College ADN Program

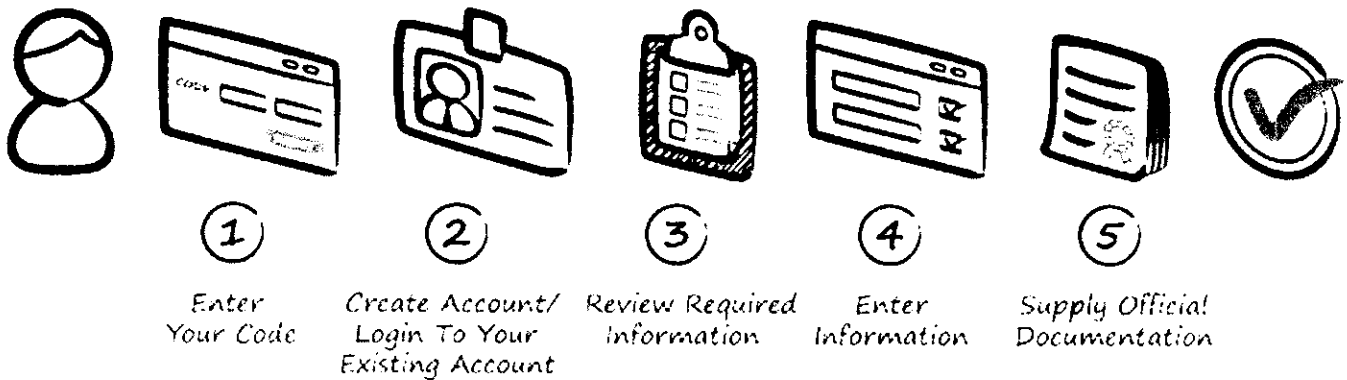
Required Qualifications for Your Program



ATTENTION Students:

We've partnered with Verified Credentials, Inc. to help you supply the required qualifications for your program. To get started, carefully follow the instructions below:

How it Works:



IMPORTANT + Use the CODE below to get started:

Program	Code
Background Check – ADN Program	PPKFW-76392

GET STARTED NOW at:

<http://scholar.verifiedcredentials.com/trenholmstate>

For Best Results - Use a laptop or desktop computer to complete this process.



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Ganville

FIRST NAME: Anastasia

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): 11/4/22 LOT #: C573CAA

EXPIRATION DATE: 01/22/2022

DATE READ: 1-6-22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Bicknell

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: _____

DATE ADMINISTERED (TEST #2): _____ LOT #: _____

EXPIRATION DATE: _____

DATE READ: _____ (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 2 RESULTS: _____ POSITIVE _____ NEGATIVE _____ REDNESS (please identify results with a ✓)

_____ mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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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



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Gavril

FIRST NAME: Anastasia

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: 11/4/02 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Raymond Fain, RN

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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

Provider:
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validation purposes.

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 IS REQUIRED.

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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INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Gawke

FIRST NAME: Anastasia

TSCC ID #: _____

SEASONAL INFLUENZA (FLU SHOT) VACCINATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE

FLU SEASON TYPICALLY BEGINS MID-SEPTEMBER.
VACCINATIONS ARE NOT AVAILABLE BEFORE THIS TIME

DATE ADMINISTERED: 11/4/22 MANUFACTURER: GalaxoSmith LOT #: 1R9NM EXPIRATION DATE: 01/30/22
Kline

SITE OF INJECTION: ☐ LEFT DELTOID ☒ RIGHT DELTOID (please identify location of injection with a ✓)

PROVIDER - PLEASE PRINT THE FOLLOWING INFORMATION:

NAME OF PERSON ADMINISTERING: Miranda Bicknell CREDENTIALS OF PERSON ADMINISTERING: RN

SIGNATURE OF PERSON ADMINISTERING: [Signature]

NAME OF OFFICE OR FACILITY: AUM PHONE #: (334) 244-3261

STREET ADDRESS: 7401 East Dr. CITY: Montgomery STATE: AL ZIP CODE: 36117

Provider:
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AUBURN UNIVERSITY MONTGOMERY
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MONTGOMERY, AL 36124-4023



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Gauvre

FIRST NAME: Anastasia

TSCC ID #: _____

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

HAVE YOU RECEIVED YOUR MMR IMMUNIZATION? 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-IMMUNIZATION IS REQUIRED.

DOSE #1

DATE OF MEASLES (RUBEOLA) TITER: 11/4/2021 POSITIVE? (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE?

DATE OF MUMPS TITER: 11/4/2021 (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE? (≥ 1.1

DATE OF RUBELLA (MEASLES) TITER: 11/4/2021 AI) NEGATIVE? (≤ 0.7 AI) (please identify results with a ✓)

measles - negative
rubella - negative

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Makanda Fair, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fair CRNP

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MONTGOMERY, AL 36124-4023

IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!
IF TITER RESULTS ARE NEGATIVE - 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.

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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HEPATITIS B IMMUNIZATION

LAST NAME: _____

FIRST NAME: _____

TSSC ID #: _____

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

HEPATITIS B IMMUNIZATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

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: _____ POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? _____ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
Please place office stamp
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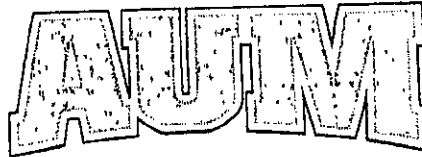
3RD VACCINATION DATE: _____
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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

AFTER COMPLETION OF 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B SURFACE ANTIGENS (anti-HBs) 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 ✓)



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Anastasia Gaulke DOB: 04/16/92 Phone: 678 505 7799

Mailing Address: P.O. BOX 20911 City: AL ST: AL Zip: 36120

Insurance Company: UMR Subscriber name: _____ DOB: 04/16/92

Insurance Contract Number: _____ Group number: _____

Screening Questions:	Yes	No	Don't Know
1) Are you sick today? (cold, fever, acute illness)	☐	☒	☐
2) Do you have allergies to any foods, medications or latex? (For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations) List _____	☐	☒	☐
3) Have you had any serious reactions from a vaccine?	☐	☒	☐
4) Have you been diagnosed with Guillain-Barre syndrome?	☐	☒	☐

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request.

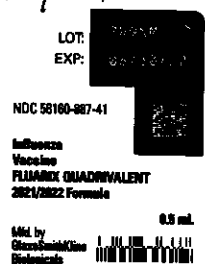
Signature: Anastasia Gaulke Date: 1/4/22

Administration Date: 1/4/22 Route: IM LD or RD Volume: 0.5cc

Administrator: M. Bicknell, RN VIS Date 08/15/2019

Manufacturer: GSK Fluorix® Quadrivalent Lot # 7R9NM Expires 06/30/2022

Temp: _____





HEPATITIS B IMMUNIZATION

LAST NAME: Gaulke

FIRST NAME: Anastasia

TSCC ID #: _____

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

HEPATITIS B IMMUNIZATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

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: _____ POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? _____ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

Provider:
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validation purposes.

**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: 05/28/21
Heplisav-B

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: Anna Yu Walsh MD

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

2ND VACCINATION DATE: 06/30/21
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

Heplisav-B

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: Anna Yu Walsh MD

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:
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validation purposes.

AFTER COMPLETION OF 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B SURFACE ANTIGENS (anti-HBs) 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 ✓)

* 2 part vaccine provided. Titer not performed. Anna Yu Walsh 01/04/22



Students may choose any licensed health care provider for needed services. The information listed below reflects costs and details for the primary care AUM Student Health Clinic that is offered to the public.

AUM Student Health Clinic

located on the AUM campus
Norma B. Moore Hall, Room 102
Phone 334-244-3281

Hours of Operation

Mon. - Fri. 8:15 a.m. - 4:30 p.m. (walk-ins are welcome; however, appointments are given priority)

Office Visits for non-AUM students:

Limited Service - \$15
Comprehensive Physical - \$35

Titers / Immunity:

Hepatitis B Surface Antigen - \$15
Varicella IgG - \$25
MMR Titer - \$55
TB - 25

Vaccinations (No Office Fee):

Tdap - \$40
Hep B - \$50
TB 2 step - \$20
MMR - \$75
Varicella - \$150



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Gaulke

FIRST NAME: Anastasia

TSCC ID #: _____

TETANUS, DIPHTHERIA, & PERTUSSIS (TDAP) VACCINATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

TDAP BOOSTER IS REQUIRED EVERY 10 YEARS AFTER INITIAL VACCINE.

DATE OF ORIGINAL TDAP VACCINATION: _____

DATE OF MOST RECENT BOOSTER: 11/4/2022

unknown - NO immunization
record presented

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Muranda Fain, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

M. Fain CNP

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