



HEALTH EXAMINATION FORM

LAST NAME: King FIRST NAME: Angelica TSCC ID #: _____ PHONE NUMBER: _____

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

Allergies (Food/Drug/Latex, etc.) <u>NKA</u>								
C O M P L E T E	Height	<u>64</u>	Weight	<u>263</u>	BP	<u>142/98</u>	Pulse	<u>81</u>
	Vision Right 20/	<u>25</u>	Left 20/	<u>30</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 1-6-2022, 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) Maranda Fair CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fair CRNP

Provider:
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MONTGOMERY, AL 36124-4023

**AUM Student Health Services
Immunization Record**

Patient Name: Angelica King

Birthdate: 2/3/1987

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap	11/12/02	Quadrant	LOT: 94619 EXP: 10/27/03				MS
			NDC 50180-842-43 Totanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adjuvanted BOOSTRIX 0.5 ml				
Td Booster			Mfg. by GlaxoSmithKline Biologals	498018			
MMR							
HEP A							
HEP B							
Other							

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID							

Initials	Signature	Initials	Signature
MS			

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STAMP ABOVE

3) Cognitive/Critical Thinking

- a) Effectively read, write and comprehend the English language
- b) Consistently and dependably engage in the process of critical thinking in order to formulate and implement safe and ethical nursing decisions in a variety of health care settings
- c) Demonstrate satisfactory performance on written examinations including mathematical computations without a calculator
- d) Satisfactorily achieve the program objectives

4) Motor Function

- a) Handle small delicate equipment/objects without extraneous movement, contamination or destruction
- b) Move, position, turn, transfer, assist with lifting or lift and carry clients without injury to clients, self or others
- c) Maintain balance from any position
- d) Stand on both legs
- e) Coordinate hand/eye movements
- f) Push/pull heavy objects without injury to client, self or others
- g) Stand, bend, walk and/or sit for 6-12 hours in a clinical setting performing physical activities requiring energy without jeopardizing the safety of the client, self or others
- h) Walk without a cane, walker or crutches
- i) Function with hands free for nursing care and transporting items
- j) Transport self and client without the use of electrical devices
- k) Flex, abduct and rotate all joints freely
- l) Respond rapidly to emergency situations
- m) Maneuver in small areas
- n) Perform daily care functions for the client
- o) Coordinate fine and gross motor hand movements to provide safe effective nursing care
- p) Calibrate/use equipment
- q) Execute movement required to provide nursing care in all health care settings
- r) Perform CPR and physical assessment
- s) Operate a computer

5) Professional Behavior

- a) Convey caring, respect, sensitivity, tact, compassion, empathy, tolerance and a healthy attitude toward others
- b) Demonstrate a mentally healthy attitude that is age appropriate in relationship to the client
- c) Handle multiple tasks concurrently
- d) Perform safe, effective nursing care for clients in a caring context
- e) Understand and follow the policies and procedures of the College and clinical agencies
- f) Understand the consequences of violating the student code of conduct
- g) Understand that posing a direct threat to others is unacceptable and subjects one to discipline
- h) Meet qualifications for licensure by examination as stipulated by the Alabama Board of Nursing
- i) Not to pose a threat to self or others
- j) Function effectively in situations of uncertainty and stress inherent in providing nursing care
- k) Adapt to changing environments and situations
- l) Remain free of chemical dependency
- m) Report promptly to clinicals and remain for 6-12 hours on the clinical unit
- n) Provide nursing care in an appropriate time frame
- o) Accepts responsibility, accountability, and ownership of one's actions
- p) Seek supervision/consultation in a timely manner
- q) Examine and modify one's own behavior when it interferes with nursing care or learning

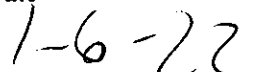
Note to all applicants: The essential functions form must be signed and dated by the student. This states that you have read and agreed to the terms. You will receive the essential functions form for the nursing program once accepted into the program for a healthcare provider to complete.

Student's Signature



Physician's Signature

Date



Date



HEPATITIS B IMMUNIZATION

LAST NAME: King

FIRST NAME: Angelica

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: _____

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 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 ✓)



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: King

FIRST NAME: Angelica

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: _____ POSITIVE? (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE?

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

DATE OF RUBELLA (MEASLES) TITER: _____ AI) NEGATIVE? (≤ 0.7 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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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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VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: King

FIRST NAME: Angelica

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: _____ POSITIVE? _____ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a ✓)

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

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 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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INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: King

FIRST NAME: Angelica

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: _____

DATE ADMINISTERED (TEST #1): _____

LOT #: _____

EXPIRATION DATE: _____

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

TEST 1 RESULTS: _____ POSITIVE _____ NEGATIVE _____ REDNESS (please identify results with a ✓)

_____ mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER 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: _____

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 _____

Provider:
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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



ANNUAL TUBERCULOSIS (TB) SKIN TEST

"TO BE COMPLETED 1 YEAR AFTER ACCEPTANCE INTO THE PROGRAM"

LAST NAME: King FIRST NAME: Angeica TSCC ID #: _____

TUBERCULIN (TB) 1 STEP SKIN TEST - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

NAME OF PERSON ADMINISTERING: _____

DATE ADMINISTERED (TEST #1): _____ LOT #: _____ EXPIRATION DATE: _____

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

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: King

FIRST NAME: Angelica

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: _____

DATE OF MOST RECENT BOOSTER: 11/6/2022

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Miranda Fair, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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