



HEALTH EXAMINATION FORM

LAST NAME: McCreary Cass FIRST NAME: Maria TSCC ID #: 10227794 PHONE NUMBER: 334 531 3482

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>69 in</u>	Weight	<u>204.3</u>	BP	<u>130/82</u>	Pulse	<u>92</u>
	Vision Right 20/	<u>20</u>	Left 20/	<u>20</u>	Corrected:	<u>Y</u> ☒ ☐ 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: depression/anxiety w/ Zoloft

The student is taking prescribed medications on a regular basis? ☒ Yes ☐ No

If yes, please list: Zoloft 100mg once daily

On the basis of my examination on this day April 18, 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) Marcinda Fair, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fair CRNP

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

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P.O. BOX 244023
MONTGOMERY, AL 36124-4023



TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Cassi ^{McCreary}

FIRST NAME: Maria

TSCC ID #: A02277994

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): 04/18/22 LOT #: CS805 AA

EXPIRATION DATE: 3/17/23

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 _____

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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



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Maria Cassi muelny

Date of Birth: 9/15/92

Student Number: _____

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: 4/18/22

Provider Signature:

Date: 4-18-22



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Cass

FIRST NAME: Maria

TSCC ID #: A02277994

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: 4/18/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) maranda Fain, UENP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fain

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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: Cassidy

FIRST NAME: Mara

TSCC ID #: A02277994

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: 4/18/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)

DATE OF MUMPS TITER: 4/18/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)

DATE OF RUBELLA (MEASLES) TITER: 4/18/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Maranda Fain, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fain

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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: McCreary
Cassidy

FIRST NAME: Maria

TSCC ID # A02277994

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: 10/01/2019 DATE OF MOST RECENT BOOSTER: _____

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Marcinda Fain

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fain CRNP

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