

AUM Student Health Services

Immunization Record

Patient Name: Breanna Mitchell

Birthdate: 7/31/88

Allergies/Medical Alert:

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	1/23/2023	1-25-23	0mm	Sanofi	65806AA	exp 3/25/23	UMB

Initials	Signature	Initials	Signature
UMB	UMB [Signature]		

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: Breanna Mitchell

Date of Birth: 07-31-88

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: Breanna Mitchell

Date: 1/23/23

Provider Signature: [Signature]

Date: 1/23/23



ANNUAL TUBERCULOSIS (TB) SKIN TEST

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

LAST NAME: Mitchell

FIRST NAME: Breanna

TSCC ID #: _____

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

NAME OF PERSON ADMINISTERING: Miranda Rickwell RN

DATE ADMINISTERED (TEST #1): 11/23/23 LOT #: GG800AA

EXPIRATION DATE: 3/25/24

DATE READ: 1-25-23 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST RESULTS: ☐ POSITIVE ☒ NEGATIVE ☐ REDNESS (please identify results with a ✓)

0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CRNP

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

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