

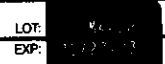
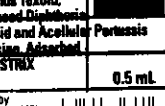
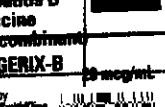
AUM Student Health Services

Immunization Record

Patient Name: Breanna Mitchell

Birthdate: 7/31/1996

Allergies/Medical Alert: NYA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap	11/11/2022	Subcut	LOT:  EXP:  NDC 58180-942-43				MB
Td Booster			Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX 0.5 mL				
MMR			Mfg by GlaxoSmithKline Biologicals 496018				
HEP A							
HEP B	11/3/2022	Subcut	LOT:  EXP:  NDC 58180-921-43				MB
Other			Hepatitis B Vaccine (Recombinant) ENGRIX-B 10 mcg/mL Mfg by GlaxoSmithKline Biologicals				

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing	11/11/22	1-13-22	0	Sanofi	CS79CAA	DFA exp 8/22/22	MB
PPD (MANTOUX)	11/21/22	1-28-22	0mm	Sanofi	CS805AA	DFA exp 3/17/23	MB
0.1 ml ID							

Initials	Signature	Initials	Signature
MB			

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MONTGOMERY, AL 36124-4023

STAMP ABOVE

Breanna Mitchell



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: mitchell

FIRST NAME: Breanna

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): 11/11/22 LOT #: C5736AA

EXPIRATION DATE: 8/22/2023

DATE READ: 1-13-22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE McL...

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: Miranda Bicknell RN

DATE ADMINISTERED (TEST #2): 1-26-22 LOT #: C5805AA

EXPIRATION DATE: 3-17-23

DATE READ: 1-28-22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 2 RESULTS: ☐ POSITIVE ☒ NEGATIVE ☐ REDNESS (please identify results with a ✓)
0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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P.O. BOX 244023
BETHESDA, MD 20814-4023

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:

Breanna Mitchell



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Mitchell

FIRST NAME: Breanna

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: 11/17/2022

*unable to determine due to
lack of information*

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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MONTGOMERY, AL 36124-4023

Breanna Mitchell



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Mitchell

FIRST NAME: Breanna

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: 1/11/20 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [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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MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: B. MitchellFIRST NAME: B. Brecenna

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: 11/12/22 POSITIVE? (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ☒) POSITIVE?

DATE OF MUMPS TITER: 11/12/22 POSITIVE? (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ☒) POSITIVE? (≥ 1.1 AI)

DATE OF RUBELLA (MEASLES) TITER: 11/12/22 POSITIVE? (≥ 1.1 AI) NEGATIVE? (≤ 0.7 AI) (please identify results with a ☒) POSITIVE?

measles (+)

mumps (+) rubella (+)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [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 _____

Provider:
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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

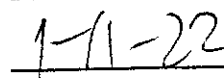
Note to all applicants: The essential functions form must be signed and dated by the student. This states that you have read and agreed to the terms. You will receive the essential functions form for the nursing program once accepted into the program for a healthcare provider to complete.

Student's Signature



Physician's Signature

Date



Date



Trenholm State
COMMUNITY COLLEGE

Alabama Community College System

Nursing Programs Essential Functions Form

The Alabama Community College System endorses the Americans' with Disabilities Act. In accordance with College policy, when requested, reasonable accommodations may be provided for individuals with disabilities.

Physical, cognitive, psychomotor, affective and social abilities are required in unique combinations to provide safe and effective nursing care. The applicant/student must be able to meet the essential functions with or without reasonable accommodations throughout the program of learning. Admission, progression and graduation are contingent upon one's ability to demonstrate the essential functions delineated for the nursing programs with or without reasonable accommodations. The nursing programs and/or its affiliated clinical agencies may identify additional essential functions. The nursing programs reserve the right to amend the essential functions as deemed necessary.

In order to be admitted and to progress in the nursing program one must possess a functional level of ability to perform the duties required of a nurse. Admission or progression may be denied if a student is unable to demonstrate the essential functions with or without reasonable accommodations.

The essential functions delineated are those deemed necessary the Alabama Community College System nursing programs. No representation regarding industrial standards is implied. Similarly, any reasonable accommodations made will be determined and applied to the respective nursing program and may vary from reasonable accommodations made by healthcare employers.

The essential functions delineated below are necessary for nursing program admission, progression and graduation and for the provision of safe and effective nursing care. The essential functions include but are not limited to the ability to:

1) Sensory Perception

- a) Visual
 - i) Observe and discern subtle changes in physical conditions and the environment
 - ii) Visualize different color spectrums and color changes
 - iii) Read fine print in varying levels of light
 - iv) Read for prolonged periods of time
 - v) Read cursive writing
 - vi) Read at varying distances
 - vii) Read data/information displayed on monitors/equipment
- b) Auditory
 - i) Interpret monitoring devices
 - ii) Distinguish muffled sounds heard through a stethoscope
 - iii) Hear and discriminate high and low frequency sounds produced by the body and the environment
 - iv) Effectively hear to communicate with others
- c) Tactile
 - i) Discern tremors, vibrations, pulses, textures, temperature, shapes, size, location and other physical characteristics
- d) Olfactory
 - i) Detect body odors and odors in the environment

2) Communication/ Interpersonal Relationships

- a) Verbally and in writing, engage in a two-way communication and interact effectively with others, from a variety of social, emotional, cultural and intellectual backgrounds
- b) Work effectively in groups
- c) Work effectively independently
- d) Discern and interpret nonverbal communication
- e) Express one's ideas and feelings clearly
- f) Communicate with others accurately in a timely manner
- g) Obtain communications from a computer

Breanna Mitchell



HEALTH EXAMINATION FORM

LAST NAME: Mitchell FIRST NAME: Breanna TSCC ID #: _____ PHONE NUMBER: _____

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

Allergies (Food/Drug/Latex, etc.)			
C O M P L E T E	Height <u>5'8"</u>	Weight <u>256</u>	BP _____
	Pulse <u>83</u>		
	Vision Right 20/ <u>20</u>	Left 20/ <u>20</u>	Corrected: ☒ YES ☐ NO

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 1/11/2022, 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) NARADA FAIR CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider:
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Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Breanna Mitchell

DATE OF BIRTH 07 / 31 / 1988
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☒	☐	☐

flu

FORM COMPLETED BY Breanna Mitchell DATE 1-11-22

FORM REVIEWED BY W.R. [signature] DATE 1/11/22

Did you bring your immunization record card with you?

yes ☐ no ☒

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.



**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: 1-11-22

Provider Signature: [Signature]

Date: 1/11/22



HEPATITIS B IMMUNIZATION

LAST NAME: mitchellFIRST NAME: Breanna

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: 11/1/2022 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) Maranda Fain, CNPPHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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MONTGOMERY, AL 36124-4023

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: 1/13/2022PHYSICIAN/NURSE PRACTITIONER SIGNATURE: [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: _____

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 ☒)