

**AUM Student Health Services  
Immunization Record**

**Patient Name:** Julia Harris

**Birthdate:** 7/21/99

**Allergies/Medical Alert:** N/A

| 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<br>PPD (MANTOUX)<br>0.1 ml ID | 11/14/22    | 1/14/22    | 0mm      | Sanofi | U573UAA | UFA exp 8/22/22 | JHS      |
|                                                  | 1/28/22     | 1-31-22    | 0mm      | Sanofi | U58USAA | exp 3/17/23 UFA | JHS      |
|                                                  |             |            |          |        |         |                 |          |

| Initials | Signature | Initials | Signature |
|----------|-----------|----------|-----------|
| JHS      | JHS       |          |           |
|          |           |          |           |
|          |           |          |           |

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



## HEALTH EXAMINATION FORM

LAST NAME: Harris FIRST NAME: Julia TSCC ID #: \_\_\_\_\_ PHONE NUMBER: 334-424-5151

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

|                                               |                  |                |          |            |            |                                                                  |       |           |
|-----------------------------------------------|------------------|----------------|----------|------------|------------|------------------------------------------------------------------|-------|-----------|
| Allergies (Food/Drug/Latex, etc.) <u>NYDA</u> |                  |                |          |            |            |                                                                  |       |           |
| C<br>O<br>M<br>P<br>L<br>E<br>T<br>E          | Height           | <u>5'1 1/2</u> | Weight   | <u>235</u> | BP         | <u>137/96</u>                                                    | Pulse | <u>95</u> |
|                                               | Vision Right 20/ | <u>20</u>      | Left 20/ | <u>20</u>  | Corrected: | <input checked="" type="checkbox"/> Y <input type="checkbox"/> 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 1/11/2022, 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) Maranda Fain CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fain CRNP

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

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## INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Harris

FIRST NAME: Julia

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): 1/11/22 LOT #: CS134AA

EXPIRATION DATE: 8/22/2022

DATE READ: 1/14/22 (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 \_\_\_\_\_

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): 1-28-22 LOT #: CS805AA

EXPIRATION DATE: 3/17/23

DATE READ: 1-31-22 (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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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



## MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Harris FIRST NAME: Julia 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? ( $\geq 1.1$  AI) NEGATIVE? ( $\leq 0.8$  AI) (please identify results with a ✓) POSITIVE?  
DATE OF MUMPS TITER: \_\_\_\_\_ ( $\geq 1.1$  AI) NEGATIVE? ( $\leq 0.8$  AI) (please identify results with a ✓) POSITIVE? ( $\geq 1.1$   
DATE OF RUBELLA (MEASLES) TITER: \_\_\_\_\_ AI) NEGATIVE? ( $\leq 0.7$  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 \_\_\_\_\_

Provider:  
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## VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Harris

FIRST NAME: Julia

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? \_\_\_\_\_ ( $\geq 1.1$  AI) NEGATIVE? \_\_\_\_\_ ( $\leq 0.8$  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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**TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION**

LAST NAME: Harris

FIRST NAME: Julia

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: \_\_\_\_\_

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) \_\_\_\_\_

PHYSICIAN/NURSE PRACTITIONER SIGNATURE \_\_\_\_\_

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**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

**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**

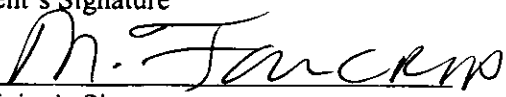
- a) Handle small delicate equipment/objects without extraneous movement, contamination or destruction
- b) Move, position, turn, transfer, assist with lifting or lift and carry clients without injury to clients, self or others
- c) Maintain balance from any position
- d) Stand on both legs
- e) Coordinate 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

1-11-2022

Date

# ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: HARRIS, JULIA BREANNA

DOB: 07/02/1994

Chart #:

Date of Service: 01/11/2022

| Vaccine Family                                                         | Type of Vaccine (no Brand Name) | Date Given (mm/dd/yy) | Age at Adm | Dose (cc/mL) | Route & Site | Mfr. | Lot # | VIS Date | Vaccinator Signature |
|------------------------------------------------------------------------|---------------------------------|-----------------------|------------|--------------|--------------|------|-------|----------|----------------------|
| <b>Tetanus, Diptheria, (Pertussis)</b><br>(e.g., Td, Tdap)             | DTP-HIB                         | 09/02/94              | 2 m        | 0.5          |              |      |       |          |                      |
|                                                                        | DTP-HIB                         | 11/04/94              | 4 m        | 0.5          |              |      |       |          |                      |
|                                                                        | DTP-HIB                         | 02/10/95              | 7 m        | 0.5          |              |      |       |          |                      |
|                                                                        | DTP-HIB                         | 11/09/95              | 16 m       | 0.5          |              |      |       |          |                      |
|                                                                        | DTAP                            | 10/30/97              | 3 y        | 0.5          |              |      |       |          |                      |
|                                                                        | DTAP                            | 02/17/99              | 4 y        | 0.5          |              |      |       |          |                      |
|                                                                        | DTAP                            | 08/18/99              | 5 y        | 0.5          |              |      |       |          | OUTSIDE CLINIC       |
|                                                                        | TDAP                            | 10/04/14              | 20 y       | 0.5          | IM           | SKB  | 9M9AA |          | OUTSIDE CLINIC       |
| <b>Hepatitis A</b><br>(e.g., HepA, HepA-HepB)                          | HEP A                           | 09/03/09              | 15 y       | 0.5          |              |      |       |          | OUTSIDE CLINIC       |
| <b>Hepatitis B</b><br>(e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB) | HEP B ADOL/PED                  | 07/04/94              | 0 m        | 0.5          |              |      |       |          |                      |
|                                                                        | HEP B ADOL/PED                  | 08/02/94              | 1 m        | 0.5          |              |      |       |          |                      |
|                                                                        | HEP B ADOL/PED                  | 02/10/95              | 7 m        | 0.5          |              |      |       |          |                      |
| <b>Human Papillomavirus</b><br>(e.g., HPV)                             | HPV (GARDASIL)                  | 09/03/09              | 15 y       | 0.5          |              |      |       |          | OUTSIDE CLINIC       |
| <b>Measles, Mumps, Rubella</b><br>(MMR, MMRV)                          | MMR                             | 11/09/95              | 16 m       | 0.5          |              |      |       |          |                      |
|                                                                        | MMR                             | 08/18/99              | 5 y        | 0.5          |              |      |       |          | OUTSIDE CLINIC       |
| <b>Meningococcal</b><br>(MCV4, MPSV4)                                  |                                 |                       |            |              |              |      |       |          |                      |
| <b>Pneumococcal</b><br>(e.g. PCV, PPV)                                 | PPV23                           | 09/03/09              | 15 y       | 0.5          |              |      |       |          | OUTSIDE CLINIC       |
|                                                                        |                                 |                       |            |              |              |      |       |          |                      |
|                                                                        |                                 |                       |            |              |              |      |       |          |                      |
| <b>Polio</b><br>(e.g., IPV, DTaP-HepB-Hib)                             | OPV                             | 09/02/94              | 2 m        | 0.5          | PO           |      |       |          |                      |
|                                                                        | OPV                             | 11/04/94              | 4 m        | 0.5          | PO           |      |       |          |                      |
|                                                                        | OPV                             | 11/09/95              | 16 m       | 0.5          | PO           |      |       |          |                      |
|                                                                        | OPV                             | 10/30/97              | 3 y        | 0.5          | PO           |      |       |          |                      |
|                                                                        | OPV                             | 02/17/99              | 4 y        | 0.5          | PO           |      |       |          |                      |
|                                                                        | OPV                             | 08/18/99              | 5 y        | 0.5          | PO           |      |       |          | OUTSIDE CLINIC       |
| <b>Varicella</b> (Var, MMRV)                                           | VARICELLA                       | 11/06/97              | 3 y        | 0.5          |              |      |       |          |                      |
|                                                                        | VARICELLA                       | 08/18/99              | 5 y        | 0.5          |              |      |       |          | OUTSIDE CLINIC       |
| <b>Influenza</b><br>(e.g., TIV, LAIV)                                  | LAIV3                           | 09/03/09              | 15 y       | 0.2          |              |      |       |          | OUTSIDE CLINIC       |
|                                                                        |                                 |                       |            |              |              |      |       |          |                      |
| <b>Zoster</b>                                                          |                                 |                       |            |              |              |      |       |          |                      |
| <b>Other</b>                                                           | HIB UNS                         | 10/30/97              | 3 y        |              |              |      |       |          |                      |
|                                                                        | ROTA RV5                        | 09/03/09              | 15 y       |              |              |      |       |          | OUTSIDE CLINIC       |

WARHAWK HEALTH SERVICES  
7461 EAST DRIVE  
RM 102 MOORE HALL  
MONTGOMERY, AL36117  
334 2443281

| PPD     | Date | Results | PPD     | Date | Results |
|---------|------|---------|---------|------|---------|
| Mantoux |      |         | Maxtoux |      |         |
| Mantoux |      |         | Mantoux |      |         |
| Mantoux |      |         | Mantoux |      |         |



**WARHAWK  
HEALTH SERVICES**

**TB Screening Questionnaire**

Name: Julia Harris

Date of Birth: 7/2/94

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?                                                                   |                                     | <input checked="" type="checkbox"/> |
| 2. Have you coughed up blood or mucus?                                                                                        |                                     | <input checked="" type="checkbox"/> |
| 3. Have you had fever, chills, or night sweats?                                                                               |                                     | <input checked="" type="checkbox"/> |
| 4. Have you had unintentional weight loss?                                                                                    |                                     | <input checked="" type="checkbox"/> |
| 5. Have you been feeling very tired?                                                                                          |                                     | <input checked="" type="checkbox"/> |
| 6. Have you lost your appetite?                                                                                               |                                     | <input checked="" type="checkbox"/> |
| 7. Have you ever had a positive TB skin test result or Positive interferon gamma release assay (IGRA) result?<br>If so, when? |                                     | <input checked="" type="checkbox"/> |
| 8. Have you ever had an abnormal chest x-ray? <u>pneumonia</u>                                                                | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Have you recently had the mucus coughed up tested for TB?                                                                  |                                     | <input checked="" type="checkbox"/> |
| 10. Have you ever been told you had TB or latent TB?                                                                          |                                     | <input checked="" type="checkbox"/> |
| 11. Have you ever taken medicine for TB?                                                                                      |                                     | <input checked="" type="checkbox"/> |
| 12. Have you ever lived with or had close contact with someone who had TB?                                                    |                                     | <input checked="" type="checkbox"/> |
| 13. Do you currently have a rash on either forearm?                                                                           |                                     | <input checked="" type="checkbox"/> |
| 14. Are you immunocompromised? (Steroids, chemotherapy, or other?)                                                            |                                     | <input checked="" type="checkbox"/> |
| 15. Have you received a live vaccine in the past 30 days?                                                                     |                                     | <input checked="" type="checkbox"/> |

**\*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: Julia Harris

Date: 1/11/22

Provider Signature: MB [Signature]

Date: 1/11/22