



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Reed

FIRST NAME: Cody

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 Ricknell, RN

DATE ADMINISTERED (TEST #1): 7/18/22 LOT #: CS805AA

EXPIRATION DATE: 3/17/23

DATE READ: 7/20/22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 1 RESULTS: 0 POSITIVE ☒ NEGATIVE REDNESS (please identify results with a ✓)

0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [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 Fain, CNP

DATE ADMINISTERED (TEST #2): 7/25/22 LOT #: CS805AA

EXPIRATION DATE: 3/17/23

DATE READ: 7-27-22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 2 RESULTS: 0 POSITIVE ☒ NEGATIVE REDNESS (please identify results with a ✓)

0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [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



HEALTH EXAMINATION FORM

LAST NAME: Reed FIRST NAME: Cody TSCC ID #: _____ PHONE NUMBER: _____

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

Allergies (Food/Drug/Latex, etc.) <u>NKDA</u>			
C O M P L E T E	Height <u>66</u>	Weight <u>143.5</u>	BP <u>131/82</u>
	Pulse <u>78</u>		
	Vision Right 20/ <u>20</u>	Left 20/ <u>30</u>	Corrected: Y ☒ N ☐
		NORMAL	ABNORMAL FINDINGS
	CBC	✓	
	Cardiovascular	✓	
	Pulses	✓	
	Heart	✓	
	Lungs	✓	
	Skin	✓	
E.N.T.	✓		
Gastrointestinal	✓		
Musculoskeletal	✓		
Neurological	✓		
Other			

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 July 18, 2022 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)

Lindsey Baeton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

[Signature]

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TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Reed

FIRST NAME: Cody

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: 06/03/2002
Dtap

DATE OF MOST RECENT BOOSTER: 07/17/2013
TDAP

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Lindsay Barton, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

[Signature]

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ADULT IMMUNIZATION RECORD

Name: REED, CODY MATTHEW

DOB: 04/02/2002

Chart #:

Date of Service: 07/18/2022

Allergies:

Reactions:

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
Tetanus, Diptheria, (Pertussis) (e.g., Td, Tdap)	DTAP	06/03/02	2 m	0.5					
	DTAP	08/07/02	4 m	0.5					
	DTAP	10/09/02	6 m	0.5					
	DTAP-HEP B-IPV	08/20/03	16 m	0.5					
	DTAP	07/19/07	5 y	0.5					
	TDAP	07/17/13	11 y	0.5		SKB	74AP3		OUTSIDE CLINIC
Hepatitis A (e.g., HepA, HepA-HepB)	HEP A	07/25/18	16 y	0.5	IM	MSD	R007388	10/15/2021	OUTSIDE CLINIC
	HEP A	04/23/19	17 y	0.5	IM	MSD	R034339	10/15/2021	OUTSIDE CLINIC
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B UNS	04/03/02	0 m	0.5					OUTSIDE CLINIC
	HEP B ADOL/PED	06/03/02	2 m	0.5					
	HEP B ADOL/PED	08/07/02	4 m	0.5					
	DTAP-HEP B-IPV	08/20/03	16 m	0.5					
Human Papiomavirus (e.g., HPV)	HPV9	07/25/18	16 y	0.5	IM	MSD	R001262	08/06/2021	OUTSIDE CLINIC
	HPV9	11/28/18	16 y	0.5	IM	MSD	R016971	08/06/2021	OUTSIDE CLINIC
Measles, Mumps, Rubella (MMR, MMRV)	MMR	04/02/03	12 m	0.5					
	MMRV	07/19/07	5 y	0.5					
Meningococcal (MCV4, MPSV4)	MCV40 (MENVEO)	07/17/13	11 y	0.5		NOV	A12129		OUTSIDE CLINIC
	MCV40 (MENVEO)	07/25/18	16 y	0.5	IM	SKB	M17058		OUTSIDE CLINIC
Pneumococcal (e.g. PCV, PPV)	PCV7	06/03/02	2 m	0.5					
	PCV7	10/09/02	6 m	0.5					
	PCV7	04/02/03	12 m	0.5					
	PCV7	08/20/03	16 m	0.5					
Polio (e.g., IPV, DTaP-HepB-Hib)	IPV	06/03/02	2 m	0.5					
	IPV	08/07/02	4 m	0.5					
	DTAP-HEP B-IPV	08/20/03	16 m	0.5					
	IPV	07/19/07	5 y	0.5					
Varicella (Var, MMRV)	VARICELLA	04/02/03	12 m	0.5					
	MMRV	07/19/07	5 y	0.5					
Influenza (e.g., TIV, LAIV)	LAIV4	11/08/14	12 y	0.2		MED	CJ2129	08/07/2015	OUTSIDE CLINIC
	IIV4 - P FREE	10/24/15	13 y	0.5	IM	SKB	32NZ7	08/07/2015	OUTSIDE CLINIC
	IIV4 - P FREE	10/15/16	14 y	0.5	IM	SKB		08/07/2015	OUTSIDE CLINIC
Zoster									
Other	HIB (PRP-T)	06/03/02	2 m						
	HIB (PRP-OMP)	06/03/02	2 m						
	HIB (PRP-OMP)	08/07/02	4 m						
	HIB (PRP-T)	08/07/02	4 m						

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		

imprint



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Reed

FIRST NAME: Cody

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 $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Lindsey Barton, CRNP

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 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: 7/25/22

DATE OF VARICELLA VACCINE #2: _____

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

Martene Fair, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

[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 _____

Instructions

Form instructions: TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

You must use the supplied form. Once completed, you will use the "add work" area to upload the scanned form. Then you will click "turn in"

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.

STEP 2 - IF YOU HAVE NOT HAD A VARICELLA/CHICKEN POX VACCINATION OR A NEGATIVE TITER RESULT - VARICELLA IMMUNIZATION IS REQUIRED.

****BE SURE TO NAME YOUR FILE AS: LAST NAME.NAME OF FILE (EX: BURNETT.VARICELLA)**



HEPATITIS B IMMUNIZATION

LAST NAME: Reed FIRST NAME: Cody TSCC ID #: _____

HAVE YOU COMPLETED A SERIES OF HEPATITIS B IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

HEPATITIS B TITER - TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER.

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: 7/18/2022 POSITIVE? ☒ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? _____ (anti-HBs ≤ 10 mIU/mL) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

Lindsey Barton, CNP

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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 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: _____

Provider:
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2ND VACCINATION DATE: _____
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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validation purposes.

3RD VACCINATION DATE: _____
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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here (if possible) for
validation purposes.

AFTER COMPLETION OF THE FULL 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B ANTIBODY TO DOCUMENT IMMUNITY:

DATE OF TITER: _____ POSITIVE? _____ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? _____ (anti-HBs ≤ 10 mIU/mL) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Reed FIRST NAME: Cody TSCC ID #: _____

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: 7/18/2012 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)
DATE OF MUMPS TITER: 7/18/2012 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)
DATE OF RUBELLA (MEASLES) TITER: 7/18/2012 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a ☒)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Linken Barton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

Linken Barton, CNP
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MONTGOMERY, AL 36124-4023

**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 _____