

AUM Student Health Services

Immunization Record

Patient Name: Cameron Hurt

Birthdate: 5-26-91

Allergies/Medical Alert: NKA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap	7/22/22	Left deltoid	LOT: [redacted] EXP: [redacted] NDC 58180-942-43	[redacted]		8/16/22	UNB
Td Booster			Tetanus Toxoid, Reduced Diphtheria Tetanus Toxoid Adsorbed Vaccine, Adsorbed BOOSTRIX	0.5 mL			
MMR			Mfr by GlaxoSmithKline Biologicals	486018			
HEP A							
HEP B	7-25-22	Right deltoid	LOT: [redacted] EXP: [redacted] NDC 58180-942-43	[redacted]		10-15-21	DM
Other			Hepatitis B Vaccine (Recombinant) ENGIRIX-B	20 mcg/mL			
			Mfr by GlaxoSmithKline Biologicals				

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	7/22/22	7-25-22	0mm	Sumati	C5805AA	exp 3/17/23	UNB
	7/29/22	8/1/22	0mm	Sumati	C5805AA	exp 3/17/23	mf

Initials	Signature	Initials	Signature
UNB	[Signature]		
DM	[Signature]		
mf	[Signature]		

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MONTGOMERY, AL 36124-4023

STAMP ABOVE



HEPATITIS B IMMUNIZATION

LAST NAME: Hurt

FIRST NAME: Cameron

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: 7/22/2022 POSITIVE? _____ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? ☒ (anti-HBs ≤ 10 mIU/mL) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fain CNP

Provider:
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here (if possible) for
validation purposes.

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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: 7/25/2022

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: M. Fain CNP

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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: _____

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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 ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Hurt FIRST NAME: Cameron 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: 7/22/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a $\checkmark$)
 DATE OF MUMPS TITER: 7/22/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.8 AI) (please identify results with a $\checkmark$)
 DATE OF RUBELLA (MEASLES) TITER: 7/22/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? _____ (≤ 0.7 AI) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

L. Barton, CRNP

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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 _____

Provider:
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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 $\checkmark$)
 DATE OF MUMPS TITER: _____ POSITIVE? _____ NEGATIVE? _____ (please identify results with a $\checkmark$)
 DATE OF RUBELLA TITER: _____ POSITIVE? _____ NEGATIVE? _____ (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Hurt

FIRST NAME: Cameron

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

DATE ADMINISTERED (TEST #1): 7/21/22 LOT #: C5805AA

EXPIRATION DATE: 3/17/23

DATE READ: 7-25-22 (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

M. Bicknell

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): 7/29/22 LOT #: C5805AA

EXPIRATION DATE: 3/17/2023

DATE READ: 8/1/22 (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

J. Hinton

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



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Hurt

FIRST NAME: Cameron

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: 7/2/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE L. Barton, CRNP

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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 ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Hurt

FIRST NAME: Cameron

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: unknown
last TD: 2/11/05

DATE OF MOST RECENT BOOSTER: 7/22/22

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

Lindsey Barton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

L. Barton, CNP

Provider:
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ADULT IMMUNIZATION RECORD

Allergies:
Reactions:

Name: HURT, CAMERON M
 DOB: 05/26/1991
 Chart #: _____
 Date of Service: 07/22/2022

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
Tetanus, Diphtheria, (Pertussis) (e.g., Td, Tdap)	TD	02/11/05	13 y	0.5					
Hepatitis A (e.g., HepA, HepA-HepB)									
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PED	09/24/99	8 y	0.5					
Human Papillomavirus (e.g., HPV)									
Measles, Mumps, Rubella (MMR, MMRV)									
Meningococcal (MCV4, MPSV4)									
Pneumococcal (e.g. PCV, PPV)									
Polio (e.g., IPV, DTaP-HepB-Hib)									
Varicella (Var, MMRV)									
Influenza (e.g., TIV, LAIV)									
Zoster									
Other	Pfizer Covid19	12/10/21	30 y	0.3	IM LD	PFR	FJ1620		OUTSIDE CLINIC
	Pfizer Covid19 (NonDiluent)	04/07/22	30 y		IM	PFR	FM0698		OUTSIDE CLINIC

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

PPD	Date	Results	PPD	Date	Results
Mantoux			Mantoux		
Mantoux			Mantoux		
Mantoux			Mantoux		



HEALTH EXAMINATION FORM

LAST NAME: Hurt FIRST NAME: Camryn TSCC ID #: _____ PHONE NUMBER: _____

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

Allergies (Food/Drug/Latex. etc.)			
NKA			
C O M P L E T E	Height	<u>71 in.</u>	Weight <u>241.2 lbs</u> BP <u>151/79</u> Pulse <u>92</u>
	Vision Right 20/	<u>20</u>	Left 20/ <u>15</u> Corrected: Y ☐ 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 07/22/12, 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) Lindsey Barton, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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