

AUM Student Health Services
Immunization Record

Patient Name: Jay Rogers

Birthdate: 12/19/2008

Allergies/Medical Alert: NKA

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	1/31/2015	2/3/25	0mm Negative	Sanofi	2CA50C1	exp 5/26 CFA	ms

Initials	Signature	Initials	Signature
ms am	ms in [Signature] Diedra Marzetta	[Signature] J. Hinton, CCRP	tb

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: Joy Rogers

Date of Birth: 12/19/08

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: Joy Rogers

Date: 1/31/25

Provider Signature: Ms. [Signature]

Date: 1/31/25