



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Beamon

FIRST NAME: Lalara

TSCC ID #: A02103188

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): 11/9/22 LOT #: 05805AA

EXPIRATION DATE: 3/17/23

DATE READ: 11/12/22 (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: Robin Blackwell, CRNP

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: Robin Blackwell, CRNP

DATE ADMINISTERED (TEST #2): 11/9/22 LOT #: 05805AA

EXPIRATION DATE: 3/17/23

DATE READ: 12/1/22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

0FA

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: Robin Blackwell, CRNP

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STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 1
P.O. BOX 244023
MONTGOMERY, AL 3612

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: Beamon FIRST NAME: Lacara TSCC ID #: _____ PHONE NUMBER: 334.312.9740

THIS FORM OWNS BY THE UNIVERSITY OF ALABAMA AT MONTGOMERY. IT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM.

Allergies (Food Drug Latex, etc.) <u>almonds, Soy, oysters, dogs, cats</u>																																							
C O M P L E T E	Height <u>62 in</u>		Weight <u>205.7</u>																																				
	BP <u>122/71</u>		Pulse <u>94</u>																																				
	Vision Right 20 <u>20</u>		Left 20 <u>25</u>																																				
	Corrected: ☒ Yes ☐ No																																						
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 30%; text-align: center;">NORMAL</th> <th style="width: 40%; text-align: center;">ABNORMAL FINDINGS</th> </tr> </thead> <tbody> <tr> <td>CBC</td> <td></td> <td>✓ Patient will Follow up with PCP for Anemia</td> </tr> <tr> <td>Cardiovascular</td> <td style="text-align: center;">✓</td> <td></td> </tr> <tr> <td>Pulses</td> <td style="text-align: center;">✓</td> <td></td> </tr> <tr> <td>Heart</td> <td style="text-align: center;">✓</td> <td></td> </tr> <tr> <td>Lungs</td> <td style="text-align: center;">✓</td> <td></td> </tr> <tr> <td>Skin</td> <td style="text-align: center;">✓</td> <td></td> </tr> <tr> <td>E.N.T.</td> <td style="text-align: center;">✓</td> <td></td> </tr> <tr> <td>Gastrointestinal</td> <td style="text-align: center;">✓</td> <td></td> </tr> <tr> <td>Musculoskeletal</td> <td style="text-align: center;">✓</td> <td></td> </tr> <tr> <td>Neurological</td> <td style="text-align: center;">✓</td> <td></td> </tr> <tr> <td>Other</td> <td></td> <td></td> </tr> </tbody> </table>				NORMAL	ABNORMAL FINDINGS	CBC		✓ Patient will Follow up with PCP for Anemia	Cardiovascular	✓		Pulses	✓		Heart	✓		Lungs	✓		Skin	✓		E.N.T.	✓		Gastrointestinal	✓		Musculoskeletal	✓		Neurological	✓		Other		
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Musculoskeletal	✓																																						
Neurological	✓																																						
Other																																							

Follow
and
treat

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: Hx: Stomach ulcers

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: Protonix

On the basis of my examination on this day 11.18.2022 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) Robin Blackwell CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CRNP

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 216023
MONTGOMERY, AL 36124-023

HEPATITIS B IMMUNIZATION

LAST NAME: Beamon

FIRST NAME: LaCara

TSCC ID #: 402103188

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: 11/9/2022 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) Robin Blackwell, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell, CNP

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STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
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: 11/11/2022

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MONTGOMERY, AL 36124-4023
PHYSICIAN/NURSE PRACTITIONER SIGNATURE: Robin Blackwell, CNP

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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: Becumon

FIRST NAME: Lalana

TSCC ID #: A02103188

WEASLES/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: 11/9/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)
DATE OF MUMPS TITER: 11/9/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a $\checkmark$)
DATE OF RUBELLA (MEASLES) TITER: 11/9/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Robin Blackwell, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Rob Blackwell CRNP AUBURN UNIVERSITY MONTGOMERY
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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 _____

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 _____



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Beamon

FIRST NAME: LaLana

TSCC ID #: A02103188

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: 9/4/01

DATE OF MOST RECENT BOOSTER: 11/1/2020

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Rubin Blackwell, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Rob Blackwell CRNP

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VARICELLA (CHICKEN POX) IMMUNIZATION

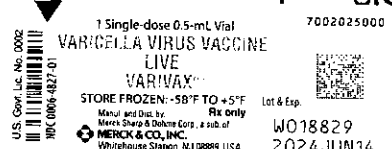
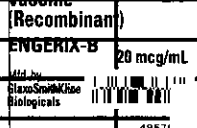
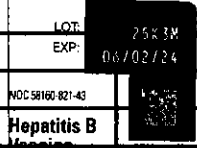
AUM Student Health Services Immunization Record

Patient Name: LaLura Beamon

Birthdate: 6/27/01

Allergies/Medical Alert: NKA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
<u>HEP B</u>	<u>11/11/2022</u>	<u>Distal Arm</u>	<u>1m</u>	<u>49571</u>		<u>10/15/21</u>	<u>MB</u>
<u>Varicella</u>	<u>11/11/2022</u>	<u>Distal Arm</u>	<u>Sub Q</u>	<u>49571</u>		<u>8/10/21</u>	<u>MB</u>
Other							



Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials

Initials	Signature	Initials	Signature
<u>MB</u>	<u>MB</u>		

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MONTGOMERY, AL 36124-4023

STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME LaCura Beammon

DATE OF BIRTH 0/27/01
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?	☒	☐	☐

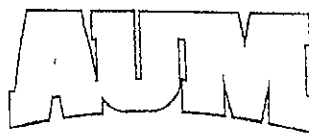
FORM COMPLETED BY LaCura Beammon DATE 11/11/22

FORM REVIEWED BY W.B. [Signature], RN DATE 11/11/22

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: Lalara Beamson

Date of Birth: 06/27/01

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: Lalara Beamson

Date: 11/9/2022

Provider Signature: MBR [Signature]

Date: 11/9/2022

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Lalara Beamon
DATE OF BIRTH 10 / 06 / 27, 2001
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?	☒	☒	☐

FORM COMPLETED BY Lalara Beamon DATE 11/09/22
FORM REVIEWED BY MR. D. KN DATE 11/9/2022

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.

BEAMON, La Cara **DOB: 06-27-2001** **#240410**

Vaccine List as of 10-01-2022

Diphtheria, Tetanus, Pertussis

Tdap Date on VIS	10-01-2020
Tdap Date on VIS	01-11-2013
DTaP-Hib Date on VIS	11-12-2002
DTaP Date on VIS	03-26-2002
DTaP-Hib-IPV Date on VIS	12-18-2001
DTaP,IPV,Hib,HepB Date on VIS	09-04-2001

HPV

HPV9 Date on VIS	02-06-2017
HPV9 Date on VIS	02-04-2016
HPV9 Date on VIS	11-18-2015

Haemophilus Influenzae Type B

DTaP-Hib Date on VIS	11-12-2002
Hib (PRP-OMP) Date on VIS	03-26-2002
DTaP-Hib-IPV Date on VIS	12-18-2001
DTaP,IPV,Hib,HepB Date on VIS	09-04-2001

Hepatitis A

Hep A, ped/adol, 2 dose Date on VIS	11-16-2013
Hep A, ped/adol, 2 dose Date on VIS	01-11-2013

Hepatitis B

Hep B, adolescent or pediatric Date on VIS	03-26-2002
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BEAMON, La Cara **DOB: 06-27-2001** **#240410**

DTaP,IPV,Hib,HepB

Date on VIS

09-04-2001

Hep B, adolescent or pediatric

Date on VIS

06-27-2001

Measles, Mumps, Rubella

MMR

Date on VIS

07-07-2006

MMR

Date on VIS

08-06-2002

Meningococcal

meningococcal MPSV4

Date on VIS

09-01-2017

meningococcal MPSV4

Date on VIS

01-11-2013

Pneumococcal

pneumococcal conjugate PCV 7

Date on VIS

03-26-2002

pneumococcal conjugate PCV 7

Date on VIS

12-08-2001

pneumococcal conjugate PCV 7

Date on VIS

09-04-2001

Polio

IPV

Date on VIS

07-15-2005

IPV

Date on VIS

08-06-2002

DTaP-Hib-IPV

Date on VIS

12-18-2001

DTaP,IPV,Hib,HepB

Date on VIS

09-04-2001

Varicella

varicella

Date on VIS

11-18-2015

varicella

Date on VIS

08-06-2002

03/30/2021-no changes reported