

AUM Student Health Services
Immunization Record

Patient Name: Allyson Hull

Birthdate: 10.9.2002

Allergies/Medical Alert: NKA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B	12/5/22	0.5 ml	1m	LOT: 2583P EXP: 03/02/23 Hepatitis B Vaccine (Recombinant) ENERGIX-B 20 mcg/ml Mfg. by GlaxoSmithKline Biologicals 495702		10/19/21	UNB
Other							

and Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	11.28.22	11/30/22	0mm	Sanofi	CS805AA	exp. 3/17/23 (4ain)	RB
	12/5/22	12/7/22	0mm	Sanofi	CS806AA	exp 3/25/23 (UEA)	UNB

Initials	Signature	Initials	Signature
RB	Rob Blackwell CRNP		

AUBURN UNIVERSITY MONTGOMERY
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P.O. BOX 244023
MONTGOMERY, AL 36124-4023



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Hull

FIRST NAME: Allyson

TSCC ID #: 1A0ZZ68585

TUBERCULIN (TB) 2 STEP MANTOUX SKIN TEST - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

STEP 1 - TEST #1:

NAME OF PERSON ADMINISTERING: Robin Blackwell, CNP

DATE ADMINISTERED (TEST #1): 11/28/22 LOT #: C9805AA

EXPIRATION DATE: 3/17/23

DATE READ: 11/30/22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 1 RESULTS: ☐ POSITIVE ☒ NEGATIVE ☐ REDNESS (please identify results with a ✓)
☐ mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell, CNP

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): 12/19/22 LOT #: C9806AA

EXPIRATION DATE: 3/25/23

DATE READ: 12/27/22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell, CNP

Provider:
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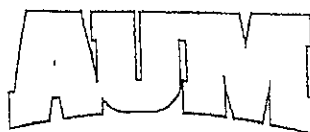
On the date read (48-72 hrs after TEST #2), your provider will evaluate, measure, and interpret the TST. Document the millimeters (e.g. 0 mm, 4 mm, 12 mm). If the 2nd TST is negative - you are done!

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



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Allyson Hull

Date of Birth: 10/09/02

Student Number: A02268585

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: Allyson Hull

Date: 11/28/22

Provider Signature: [Signature]

Date: 11/28/2022

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Allyson hull

DATE OF BIRTH 10 / 09 / 02
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 Allyson hull DATE 12/5/22

FORM REVIEWED BY [Signature] DATE 12/9/22

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.



HEALTH EXAMINATION FORM

LAST NAME: Hull FIRST NAME: Allyson TSCC ID #: A02268585 PHONE NUMBER: 334-465-9631

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>67 in</u>	Weight	<u>193.4</u>	BP	<u>125/78</u>	Pulse	<u>80</u>
	Vision Right		<u>20/25</u>	Left		<u>20/25</u>	Corrected: ☒ Yes ☐ No	

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 11/28/02, 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 Bladwell CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Bladwell CRNP

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HEPATITIS B IMMUNIZATION

LAST NAME: Hull

FIRST NAME: Allyson

TSCC ID #: A02268585

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

HEPATITIS B IMMUNIZATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

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: 11/26/02 POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? ☒ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Rob Blackwell, CRP

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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: 11/26/02

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: Rob Blackwell, CRP

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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validation purposes.

AFTER COMPLETION OF 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B SURFACE ANTIGENS (anti-HBs) TO DOCUMENT IMMUNITY:

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



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Hull

FIRST NAME: Allyson

TSCC ID #: A02268585

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: 11/28/22 **POSITIVE?** (≥ 1.1 AI) **NEGATIVE?** (≤ 0.8 AI) (please identify results with a ✓) **POSITIVE?**
DATE OF MUMPS TITER: 11/28/22 (≥ 1.1 AI) **NEGATIVE?** (≤ 0.8 AI) (please identify results with a ✓) **POSITIVE?** (≥ 1.1
DATE OF RUBELLA (MEASLES) TITER: 11/28/22 AI) **NEGATIVE?** (≤ 0.7 AI) (please identify results with a ✓)

positive for mmr immunity

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

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

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VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Hull

FIRST NAME: Allyson

TSCC ID #: A02268585

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: 11/28/2022 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell

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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 _____

Provider:
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ANNUAL TUBERCULOSIS (TB) SKIN TEST

"TO BE COMPLETED 1 YEAR AFTER ACCEPTANCE INTO THE PROGRAM"

LAST NAME: Hull

FIRST NAME: Allyson

TSCC ID #: A02268585

TUBERCULIN (TB) 1 STEP SKIN TEST - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

NAME OF PERSON ADMINISTERING: _____

DATE ADMINISTERED (TEST #1): _____

LOT #: _____

EXPIRATION DATE: _____

DATE READ: _____ (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST RESULTS: ☐ POSITIVE ☐ NEGATIVE ☐ REDNESS (please identify results with a ✓)

_____ mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Hull

FIRST NAME: Allison

TSCC ID #: A02268585

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: 3/14/08 C D Twp DATE OF MOST RECENT BOOSTER: 7/22/2014

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: HULL, ALLYSON TAYLOR

DOB: 10/09/2002

Chart #:

Date of Service: 11/17/2022

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)	DTAP	03/14/03	5 m	0.5					
	DTAP	06/09/03	8 m	0.5					
	DTAP	07/28/04	21 m	0.5					
	DTAP	10/17/06	4 y	0.5					
	TDAP	07/22/14	11 y	0.5					OUTSIDE CLINIC
Hepatitis A (e.g., HepA, HepA-HepB)	HEP A	10/17/06	4 y	0.5					
	HEP A	07/22/14	11 y	0.5	IM RD	SKB	7Y5TM		OUTSIDE CLINIC
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PED	12/10/02	2 m	0.5					OUTSIDE CLINIC
	HEP B - HIB	03/14/03	5 m	0.5					
	HEP B - HIB	03/01/04	16 m	0.5					
Human Papillomavirus (e.g., HPV)	HPV (GARDASIL)	07/22/14	11 y	0.5	IM LD	MSD	K001500		OUTSIDE CLINIC
	HPV (GARDASIL)	09/02/14	11 y	0.5		MSD			
	HPV (GARDASIL)	08/07/15	12 y	0.5					OUTSIDE CLINIC
Measles, Mumps, Rubella (MMR, MMRV)	MMR	03/01/04	16 m	0.5					
	MMRV	11/13/07	5 y	0.5					OUTSIDE CLINIC
Meningococcal (MCV4, MPSV4)	MCV4P (MENACTRA)	07/22/14	11 y	0.5	IM RD	PMC	U4798AA		OUTSIDE CLINIC
Pneumococcal (e.g., PCV, PPV)									
Polio (e.g., IPV, DTaP-HepB-Hib)	IPV	12/10/02	2 m	0.5					OUTSIDE CLINIC
	IPV	03/14/03	5 m	0.5					
	IPV	07/28/04	21 m	0.5					
	IPV	10/17/06	4 y	0.5					
Varicella (Var, MMRV)	VARICELLA	08/10/06	3 y	0.5					
	MMRV	11/13/07	5 y	0.5					OUTSIDE CLINIC
Influenza (e.g., TIV, LAIV)	INFLUENZA UNS	10/17/06	4 y	0.25 0.5					
Zoster									
Other	Pfizer Covid19	01/11/22	19 y		IM	PFR	FL3209		OUTSIDE CLINIC
	Pfizer Covid19 (NonDiluent)	04/19/22	19 y		IM	PFR	FJ4989		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		