



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Gordon

FIRST NAME: DeShay

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 RN

DATE ADMINISTERED (TEST #1): 11/29/22 LOT #: C5805AA

EXPIRATION DATE: 3/17/23

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

TEST 1 RESULTS: 0 mm (please provide measure in millimeters) ☒ POSITIVE ☒ NEGATIVE ☐ REDNESS (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robi 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: Dedra Marzette, MA

DATE ADMINISTERED (TEST #2): 12/6/22 LOT #: C5806AA

EXPIRATION DATE: 3/17/23

DATE READ: 12/8/22 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robi Blackwell CRNP

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023

Provider:
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here (if possible) for
validation purposes.

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: Gordon FIRST NAME: Devin TSCC ID #: _____ PHONE NUMBER: _____

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

Allergies (Food/Drug/Latex, etc.) <u>NKA</u>				
C O M P L E T E	Height <u>68</u>	Weight <u>179.3</u>	BP <u>132/80</u>	Pulse <u>92</u>
	Vision Right 20/ <u>15</u>	Left 20/ <u>25</u>	Corrected: ☒ YES ☐ NO	
		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 11/29/02, 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 Blackwell CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CRNP

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TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Gordon

FIRST NAME: Devin

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: 11/6/93 & DTaP DATE OF MOST RECENT BOOSTER: 11/29/2022

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CNP

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VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Gordon

FIRST NAME: Deomy

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: 11/29/2022 POSITIVE? ☒ (≥ 1.1 AU) NEGATIVE? ☐ (≤ 0.8 AU) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell 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 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 _____

Montgomery County Health Department
Immunization Division
3060 Mobile Highway
Montgomery, Alabama 36108
334-293-6448

Provider:
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here (if possible) for
validation purposes.

*See Attach Immunization
Record CL*



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Gordon

FIRST NAME: Destiny

TSCC ID #: AW 619249

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: 11/29/22 POSITIVE? (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE?
 DATE OF MUMPS TITER: 11/29/22 (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE? (≥ 1.1 AI)
 DATE OF RUBELLA (MEASLES) TITER: 11/29/22 AI) NEGATIVE? (≤ 0.7 AI) (please identify results with a ✓)

positive titer for mmr

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CRNP

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Montgomery County Health Department
Immunization Division
3060 Mobile Highway
Montgomery, Alabama 36108
334-293-6448

IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!
IF TITER RESULTS ARE NEGATIVE - COMPLETE STEP 2 BELOW.

*See attach
Immunization
Record CP*

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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HEPATITIS B IMMUNIZATION

LAST NAME: Gordon

FIRST NAME: DeMilly

TSSC ID #: _____

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: 11/29/02 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 Blockmeyer, RN

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blockmeyer, RN

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023

Provider:
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validation purposes.

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: Montgomery County Health Department

Montgomery County Health Department
Immunization Division
3060 Mobile Highway
Montgomery, Alabama 36108
334-293-6448
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Immunization Division
3060 Mobile Highway
Montgomery, Alabama 36108
334-293-6448

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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Montgomery County Health Department
Immunization Division
3060 Mobile Highway
Montgomery, Alabama 36108
334-293-6448

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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Montgomery County Health Department
Immunization Division
3060 Mobile Highway
Montgomery, Alabama 36108
334-293-6448

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 $\checkmark$)

ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: GORDON, DESTINY
 DOB: 11/10/1992
 Chart #:
 Date of Service: 11/29/2022

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	01/06/93	1 m	0.5					
	DTAP	01/12/95	2 y	0.5					
	DTAP	03/14/95	2 y	0.5					
	DTAP	10/24/95	2 y	0.5					
	DTAP	06/12/97	4 y	0.5					OUTSIDE CLINIC
	TDAP	03/07/06	13 y	0.5					OUTSIDE CLINIC
	TDAP	06/07/07	14 y	0.5					OUTSIDE CLINIC
Hepatitis A (e.g., HepA, HepA-HepB)									
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PED	11/10/92	0 m	0.5					
	HEP B UNS	01/06/93	1 m	0.5					
	HEP B UNS	01/12/95	2 y	0.5					
Human Papillomavirus (e.g., HPV)	HPV (GARDASIL)	11/19/13	21 y	0.5					OUTSIDE CLINIC
	HPV (GARDASIL)	10/14/15	22 y	0.5					OUTSIDE CLINIC
	HPV (GARDASIL)	07/11/16	23 y	0.5					OUTSIDE CLINIC
Measles, Mumps, Rubella (MMR, MMRV)	MMR	03/14/95	2 y	0.5					
	MMR	06/12/97	4 y	0.5					OUTSIDE CLINIC
Meningococcal (MCV4, MPSV4)	MENINGOCOCCAL UNS	03/07/06	13 y	0.5					OUTSIDE CLINIC
Pneumococcal (e.g. PCV, PPV)									
Polio (e.g., IPV, DTaP-HepB-Hib)	OPV	01/06/93	1 m	0.5					
	OPV	01/12/95	2 y	0.5					
	OPV	03/14/95	2 y	0.5					
	IPV	06/12/97	4 y	0.5					OUTSIDE CLINIC
Varicella (Var, MMRV)	VARICELLA	06/12/97	4 y	0.5					OUTSIDE CLINIC
	VARICELLA	10/14/08	15 y	0.5					
Influenza (e.g., TIV, LAIV)									
Zoster									
Other	HIB UNS	01/06/93	1 m						
	HIB UNS	01/12/95	2 y						
	HIB UNS	03/14/95	2 y						

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

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

ADULT IMMUNIZATION RECORD

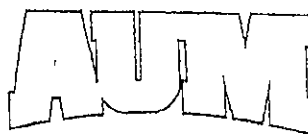
Allergies:
Reactions:

Name: GORDON, DESTINY
 DOB: 11/10/1992
 Chart #:
 Date of Service: 11/29/2022

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)									
Hepatitis A (e.g., HepA, HepA-HepB)									
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)									
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	09/19/21	28 y		IM	PFR	FF8730		OUTSIDE CLINIC
	Pfizer Covid19	12/12/21	29 y		IM	PFR	FJ1611		OUTSIDE CLINIC

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



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Destiny Galdon

Date of Birth: 11-10-92

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?		✓

Today - 11/29/22
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: Destiny Galdon

Date: 11-29-22

Provider Signature: [Signature] RN

Date: 11/29/2022

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Destiny Gordon

DATE OF BIRTH 11/10/92
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 Destiny Gordon DATE 11/25/22
FORM REVIEWED BY MSM DRN DATE 11/29/22

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.

**AUM Student Health Services
Immunization Record**

Patient Name: Destiny Gordon

Birthdate: 11.10.92

Allergies/Medical Alert: NKA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap	11/9/22	Ubelaid	LOT: [REDACTED] NDC 58100-042-43 Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX	[REDACTED]		8/16/21	UNB
Td Booster		1m	0.5 ml				
MMR			Mfg. by [REDACTED] 496018				
HEP A							
HEP B							
Other							

(LFA) Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	11.09.22	12/1/22	0mm	Sanofi	C5805AA exp: 3.17.23	(LFA)	UNB
	12/6/22	12/8/22	0mm	Sanofi	C5806AA exp: 3/17/23	(LFA)	DM

Initials	Signature	Initials	Signature
UNB	UNB [Signature]		

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