

AUM Student Health Services

Immunization Record

Patient Name: Aineta Dixon

Birthdate: 2.17.97

Allergies/Medical Alert: NKA

Immunization	Date	Site	Dose	MFR	Comments	V.I.S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B	12/12/22	0.5ml				10/19/21	MB
Other	12/12/22	0.5ml				8/16/21	MB

LOT: 25K3M
EXP: 06/02/24
NDC 58106-921-43
Hepatitis B Vaccine
(Recombinant)
ENGERIX-B
20 mcg/mL
Mfg. by: GlaxoSmithKline
Biologicals
495702

1 Single-dose 0.5-mL Vial
VARICELLA VIRUS VACCINE
LIVE
VARIVAX
STORE FROZEN -58°F TO +5°F
Lot & Exp. W018829
2024 JUN14

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	12/15/22	12/17/22	0mm	Sanofi	C580VAA	exp 3/25/23	MB
	12/15/22	12/17/22	0mm	Sanofi	C580VAA	exp 3/25/23	MB

Initials	Signature	Initials	Signature
MB	MB m Dixon		

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

STAMP ABOVE



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Dixon

FIRST NAME: Aineta

TSCC ID #: _____

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: 12/6/12

DATE OF MUMPS TITER: 12/6/12

DATE OF RUBELLA (MEASLES) TITER: 12/6/12

positive mmr titer

POSITIVE? (≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE?
(≥ 1.1 AI) NEGATIVE? (≤ 0.8 AI) (please identify results with a ✓) POSITIVE?
(≥ 1.1 AI) NEGATIVE? (≤ 0.7 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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STUDENT HEALTH CENTER
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P.O. BOX 244023
MONTGOMERY, AL 36124-4023

Provider:
Please place office stamp
here (if possible) for
validation purposes.

**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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INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Dixon

FIRST NAME: Aletha

TSCC ID #: _____

SEASONAL INFLUENZA (FLU SHOT) VACCINATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE

FLU SEASON TYPICALLY BEGINS MID-SEPTEMBER
VACCINATIONS ARE NOT AVAILABLE BEFORE THIS TIME

DATE ADMINISTERED: 12/5/22 MANUFACTURER: GSK LOT #: m3P5B EXPIRATION DATE: 01/30/23

SITE OF INJECTION: ☒ LEFT DELTOID ☐ RIGHT DELTOID (please identify location of injection with a ✓)

PROVIDER - PLEASE PRINT THE FOLLOWING INFORMATION:

NAME OF PERSON ADMINISTERING: Miranda Bicknell CREDENTIALS OF PERSON ADMINISTERING: RN

SIGNATURE OF PERSON ADMINISTERING: [Signature] RN

NAME OF OFFICE OR FACILITY: AUM PHONE #: (334) 244-3281

STREET ADDRESS: 7401 East Dr. CITY: Montgomery STATE: AL ZIP CODE: 36117

Provider:
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VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Dixon

FIRST NAME: Aletra

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: 12/5/22

POSITIVE? _____ (≥ 1.1 AI) NEGATIVE? ☒ (≤ 0.8 AI) (please identify results with a ✓)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT): Lindsey T. Baeten, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: [Signature]

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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: 12/12/22

DATE OF VARICELLA VACCINE #2: _____

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT): Lindsey T. Baeten, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: [Signature]

Provider:
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INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Dixon

FIRST NAME: Anetra

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): 12/6/22

LOT #: C5806AA

EXPIRATION DATE: 3/25/23

DATE READ: 12/7/22 (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 J. Banton, CRP

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): 12/12/22 LOT #: C5806AA

EXPIRATION DATE: 3/25/23

DATE READ: 12/14/22 (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. Banton, CRP

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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



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Dixon

FIRST NAME: Ahetra

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: 9/22/08

DATE OF MOST RECENT BOOSTER: 11/2/21

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT)

Lindsey T. Barton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

Lindsey T. Barton, CNP

Provider:
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validation purposes.

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HEPATITIS B IMMUNIZATION

LAST NAME: Dixon

FIRST NAME: Aneira

TSCC 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: 12/5/22 POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? _____ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

Provider:
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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: 12/12/22

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
Please place office stamp
here (if possible) for
validation purposes.

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
Please place office stamp
here (if possible) for
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 ✓)

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Ametel Dixon
DATE OF BIRTH 02 / 17 / 1997
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.

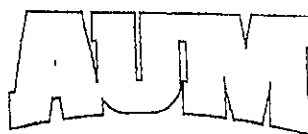
none known

	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 Ametel Dixon DATE 12/05/2022
FORM REVIEWED BY URN RN DATE 12/15/2022

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.



**WARHAWK
HEALTH SERVICES**

TB Screening Questionnaire

Name: Almetra Dixon

Date of Birth: 02/17/1997

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?		✓

② arm
due to
everest
breakout

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: Almetra Dixon

Date: 02/05/2022

Provider Signature: [Signature] RN

Date: 12/5/2022

Auburn Montgomery Student Health Services
 7461 East Dr
 Montgomery, AL 36117
 (334) 244-3281

Laboratory Results

Patient Name: ALNETRA DIXON

Order Date: 12/05/2022

MRN: 5250

DOB: 02/17/1997

Phone: () -

Gender: FEMALE

Placer Order ID: 00846244

Physician: BLACKWELL

Filler Order ID: AL069215Y

Physician ID: 1295276632

Specimen Date: 12/05/2022 4:42 PM

Fasting:

Result Date: 12/06/2022 9:14 PM

Disposition:

Specimen Source: SOURCE, UNSPECIFIED

MMR (IGG) PANEL 6259 STATUS: F

Test Name	Abnormal	Result Value	Unit of Measure	Ref Range	Status	Producer ID
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MEASLES AB (IGG), IMMUNE STATUS

125.00

AU/mL

F

AT

AU/mL Interpretation

<13.50 Not consistent with immunity

13.50-16.49 Equivocal

>16.49 Consistent with immunity

The presence of measles IgG suggests immunization or past or current infection with measles virus.

For additional information, please refer to
<http://education.QuestDiagnostics.com/faq/FAQ162>
 (This link is being provided for informational/
 educational purposes only.)

MUMPS VIRUS AB (IGG), IMMUNE STATUS

64.80

AU/mL

F

AT

AU/mL Interpretation

<9.00 Not consistent with immunity

9.00-10.99 Equivocal

>10.99 Consistent with immunity

The presence of mumps IgG antibody suggests immunization or past or current infection with mumps virus.

RUBELLA AB (IGG), IMMUNE STATUS

1.40

Index

F

AT

Index Interpretation

<0.90 Not consistent with immunity

0.90-0.99 Equivocal

> or = 1.00 Consistent with immunity

The presence of rubella IgG antibody suggests immunization or past or current infection with rubella virus.

HEP B SURFACE AB ON 8475 STATUS: F

Test Name	Abnormal	Result Value	Unit of Measure	Ref Range	Status	Producer ID
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HEPATITIS B SURFACE AB IMMUNITY, QN

L

<5

mIU/mL

> OR = 10

F

AT

Confidential

Auburn Montgomery Student Health Services
7461 East Dr
Montgomery, AL 36117
(334) 244-3281

Laboratory Results

Patient Name: ALNETRA DIXON

Order Date: 12/05/2022

MRN: 5250

DOB: 02/17/1997

Phone: () -

Gender: FEMALE

Placer Order ID: 00846244

Physician: BLACKWELL

Filler Order ID: AL069215Y

Physician ID: 1295276632

Specimen Date: 12/05/2022 4:42 PM

Fasting:

Result Date: 12/06/2022 9:14 PM

Disposition:

Specimen Source: SOURCE, UNSPECIFIED

Patient does not have immunity to hepatitis B virus.

For additional information, please refer to
<http://education.questdiagnostics.com/faq/FAQ105>
(This link is being provided for informational/
educational purposes only).

VZV AB IGG 4439 STATUS: F

Test Name	Abnormal	Result Value	Unit of Measure	Ref Range	Status	Producer ID
VARICELLA ZOSTER VIRUS ANTIBODY (IGG)	L	<135.00	index		F	AT

Index	Interpretation
<135.00	Negative - Antibody not detected
135.00 - 164.99	Equivocal
> or = 165.00	Positive - Antibody detected

A positive result indicates that the patient has antibody to VZV but does not differentiate between an active or past infection. The clinical diagnosis must be interpreted in conjunction with the clinical signs and symptoms of the patient. This assay reliably measures immunity due to previous infection but may not be sensitive enough to detect antibodies induced by vaccination. Thus, a negative result in a vaccinated individual does not necessarily indicate susceptibility to VZV infection. A more sensitive test for vaccination-induced immunity is Varicella Zoster Virus Antibody Immunity Screen, ACIF.

Lab

QUEST DIAGNOSTICS-ATLANTA(11D0255931) - AT
1777 MONTREAL CIRCLE TUCKER, GA 30084-6802

YOUNG ANDREW

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HEALTH EXAMINATION FORM

LAST NAME: Dixon FIRST NAME: Almirena TSCC ID #: _____ PHONE NUMBER: 334-314-2001

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>63in</u>	Weight	<u>277.2</u>	BP	<u>141/89</u>	Pulse	<u>67</u>
	Vision Right 20/	<u>25</u>	Left 20/	<u>25</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 12.7.22, 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 CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CNP

Provider:
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**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Almeta Dixon DOB: 02/17/1997 Phone: (334) 314-7604

Mailing Address: 2047 Johnson St City: Montgomery ST: AL Zip: 36110

Insurance Company: BCBS Subscriber name: Alicia Owens ^{Walker} DOB: 03/11/1975

Insurance Contract Number: EDU 811754890 Group number: K400

Screening Questions:	Yes	No	Don't Know
1) Are you sick today? (cold, fever, acute illness)	☐	☒	☐
2) Do you have allergies to any foods, medications or latex? (For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations) List _____	☐	☐	☒
3) Have you had any serious reactions from a vaccine?	☐	☒	☐
4) Have you been diagnosed with Guillain-Barre syndrome?	☐	☒	☐

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request,

Signature [Signature] Date 08/15/2022
Administration Date 12/15/22 Route: IM LD or RD Volume: 0.5ml
Administrator M. Bicknell, RN VIS Date 08/15/2019
Manufacturer: GSK Fluarix® Quadrivalent Lot # M3R5B Expires 06/30/2023
Temp: 98.2

