

AUM Student Health Services

Immunization Record

Patient Name: Jessica Mazaheri

Birthdate: 7/23/88

Allergies/Medical Alert: N/A

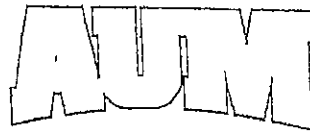
Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B							
Other							

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	1/10/2023	1/12/23	0mm	Sumati	CS807AA	exp 9/19/23 (UFA)	UNR

Initials	Signature	Initials	Signature
UNR	UNR [Signature]		

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: Jess Mafaheri

Date of Birth: 07.23.88

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: Jess Mafaheri

Date: 1.10.22

Provider Signature: W.S. [Signature] RN

Date: 1/10/2023