

**AUM Student Health Services
Immunization Record**

Patient Name: Joyce Williford

Birthdate: 11/6/1975

Allergies/Medical Alert: NKA

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
	12/12/13	12/14/13	Imm	SanoFi	2CA9301	exp 10/20 @FA	MS
			Negative				

Initials	Signature	Initials	Signature
MS	MS, RN		

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: Joyce Williford

Date of Birth: 01-16-1975

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: Joyce Williford

Date: 12/12/23

Provider Signature: MB [Signature] RN

Date: 12/12/23