

Immunization Record

Patient Name: Krystal NielBirthdate: 02/14/1986Allergies/Medical Alert: NKA

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

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	7/30/24	8/1/2024	0 mm Sanofi Negative	30A1801	exp 4/27 (C)FA		ms

Initials	Signature	Initials	Signature
ms	ms m O, PN		

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: Kristal M. Neri

Date of Birth: 02/14/1990

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?		X
2. Have you coughed up blood or mucus?		X
3. Have you had fever, chills, or night sweats?		X
4. Have you had unintentional weight loss?		X
5. Have you been feeling very tired?	X	
6. Have you lost your appetite?		X
7. Have you ever had a positive TB skin test result or Positive interferon gamma release assay (IGRA) result? If so, when?		X
8. Have you ever had an abnormal chest x-ray?		X
9. Have you recently had the mucus coughed up tested for TB?		X
10. Have you ever been told you had TB or latent TB?		X
11. Have you ever taken medicine for TB?		X
12. Have you ever lived with or had close contact with someone who had TB?		X
13. Do you currently have a rash on either forearm?		X
14. Are you immunocompromised? (Steroids, chemotherapy, or other?)	X	
15. Have you received a live vaccine in the past 30 days?		X

currently
coughing
sore throat
etc.

upus

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: Kristal M. Neri

Date: 07/30/2024

Provider Signature: [Signature]

Date: 7/30/2024