

Immunization Form

To ensure the health and safety of our campus, immunizations against communicable diseases is extremely important. Vaccination against Measles, Mumps, Rubella (MMR), Tetanus, Diphtheria and Pertussis (Tdap), and proof of negative Tuberculosis is required of all students entering Auburn Montgomery. This form must be completed and is the preferred document for proof of immunizations and TB testing.

Complete and Return to: **Student Health Center**
Attn: Immunizations
PO Box 244023
Montgomery, AL 36124
(334) 244-3281 Fax (334) 244-3396

Name Queen Meggan Student Number 903237633
Address 425 Opelika Rd Apt 279 Auburn AL 36830
Street City State Zip Code
Phone Number (334)-614-6499 E-mail Address mqueen@aum.edu Date of Birth 02/21/1996 Date of Enrollment 06/03/19

REQUIRED IMMUNIZATIONS

Tuberculosis Screening (within 6 months prior to semester student is to begin at AUM.)

Date Given _____ (Date of reading, within 48 to 72 hours of date given) TB skin test (PPD) _____ / _____ / _____

Results: Positive _____ mm Negative _____ mm

If positive, you must attach a radiology report from chest X-ray and documentation of treatment.

Tetanus, Diphtheria, Pertussis (Tdap) Vaccine. Students without previous documentation of a Tdap vaccine should have one dose within the last 10 years. Other students should be current to maintain their status throughout their entire academic career.

Date of Tdap vaccine: 04/11/2018

Measles, Mumps, Rubella (MMR)

Auburn Montgomery University requires that all students born after 1956 must have had 2 doses of a measles containing vaccine (MMR) prior to registration. One dose must have been after 1980. Lab antibody titers (IgG) for Measles, Mumps and Rubella are acceptable. Please attach documentation to the back of the form.

Date of First Dose 02/24/1997 Date of Second Dose 01/18/2001

OPTIONAL IMMUNIZATIONS (These immunizations are not required by the university but are recommended by the American College Health Association.)

Hepatitis B: 03/07/1996 04/15/1996 08/26/1996
1st 2nd 3rd

Varicella (Chickenpox) Vaccine: 01/18/2001 08/01/2007
1st 2nd

Meningococcal (MenACWY) Vaccine: _____ / _____ / _____ (One dose on or after the 16th birthday)
1st 2nd

Meningococcal B Vaccine _____ / _____ / _____

I certify that the above dates and vaccinations are true.

Signature of Licensed Health Care Professional

Date

License Number or Office Stamp

(Adopted 1/12, Revised 8/2016)

STATE OF ALABAMA

CERTIFICATE OF IMMUNIZATION

Meggan Queen

CHILD

2/21/1996

DATE OF BIRTH

PARENT OR GUARDIAN

Diphtheria, Tetanus, and Pertussis Vaccine (Identify vaccine given) A medical exemption (see reverse side) is required for children less than 7 years of age who are not given pertussis vaccine.

DTaP	DTaP	DTaP	DTaP	DTaP	Tdap
4/15/1996	6/20/1996	8/26/1996	6/6/1997	1/18/2001	8/1/2007
Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year

Polio Vaccine (Circle vaccine given):

IPV	IPV	IPV	IPV	IPV
4/15/1996	6/20/1996	2/24/1997	1/18/2001	
Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year

Measles, Mumps, and Rubella Vaccine (Identify vaccine given):

MMR	MMR
2/24/1997	1/18/2001
Mo/Day/Year	Mo/Day/Year

Haemophilus influenzae Type b (Required for Day Care and Head Start only. Please record for historical information):

4/15/1996	6/20/1996	8/26/1996	6/6/1997
Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year

Varicella Vaccine (Required for Day Care and Head Start September 2000. Required for Kindergarten entry Fall of 2001 and for a grade higher each successive year.)

In lieu of Varicella Vaccine

History of Chickenpox

1/18/2001	8/1/2007	Positive Varicella	Mo/Day/Year
Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year

Not required for school attendance. Please record for historical information. Do not expire this certificate for these vaccines.

Hepatitis B

3/7/1996	4/15/1996	8/26/1996
Mo/Day/Year	Mo/Day/Year	Mo/Day/Year

Pneumococcal Conjugate Vaccine

Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year
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Other: Specify Vaccine (not to include TB skin test)

Vaccine L.T. RotaTeq Date Vaccine L.T. Gardasil Date 8/1/2007 Vaccine Date

Authorized Medical Signature

4/22/2010
Date

Flowers and Mansfield Pediatrics
Name of Clinic

L.T. - Lagumadunen
medical receptionist

Auburn University Medical Clinic
400 Lem Morrison Drive
Auburn University, AL 36849-5349

TELEPHONE: (334) 844-4416

FAX: (334) 528-6780

E-Mail: aumcmedrecords@eame.org

Hours of Operation:

Monday - Friday 8 a.m. - 6 p.m.
Except Thursday 9 a.m. - 6 p.m.
Saturday 8 a.m. - 12 p.m.
(Hours Subject to Change)

To Make an Appointment: Please Call (334) 844-4416
WWW.AUBURN.EDU/MEDICAL

INSURANCE INFORMATION

What is the name of your insurance company? AllKids
Subscriber# KID809589290 Group # 05000 Plan # _____
What is your insurance company's claims address 6065 450 Riverchase Pkwy East
Birmingham AL 35244
Who is the policy holder? Robin Queen Gender: (circle one) M F
What is your relationship to the policy holder? child DOB of Policy Holder 9-8-69
Does your plan require a co-payment? yes If so, how much? \$13
What are the limits (age, full time status, etc.) on the policy for your coverage as a student? 19 years of age
Does your plan provide for "out of area" coverage for you? yes Does your plan provide prescription benefits? yes

Please attach a legible copy of the front and back of your insurance card. If you have more than one insurance coverage, please provide both clearly stating which is primary and which is secondary. We will also need each policy holder's name, date of birth, gender and relationship to file the secondary insurance.

BILLING INFORMATION

Patient's Relationship to billing Person(s): Self ☒ Spouse ☐ Child ☐ Other ☐
Name of Billing Person(s): Megann Lynn Taylor Queen
(First) (Middle) (Last)
Telephone #s Home: (334) 614-6499 Work: () - () - () Cellular: () - () - ()
Address: 202 W Longleaf 22SA Auburn AL 36832
(Street / P.O. Box) (City) (State) (Zip)

I hereby authorize Auburn University Medical Clinic (AUMC) to release information from my medical records as may be required or requested by my insurance company, employer, or any other persons liable to AUMC for payment of all or part of the charges pertaining to my office visits. I also authorize AUMC to act as my agent when filing insurance claims on my behalf. I directly assign to AUMC all insurance benefits and agree that any benefits payments sent to me will be promptly forwarded to AUMC. I understand that I am responsible for all charges incurred at the Auburn University Medical Clinic regardless of the degree to which my insurance covers the services rendered.

Billing Disclosure - If I have insurance, I understand balances will be filed with insurance companies under most circumstances. Items not fully paid or otherwise accounted for by an insurance company will be billed to me or my designated responsible party. After a period of time, uncollected balances may be collected through a collection agency including any additional costs related to the collection process. Holds may be placed on my registration/graduation. Any outstanding balances are my responsibility. If any checks are returned, there will be a "returned check" fee assessed for a minimum of \$30.00 and I may be referred to the "Worthless Check Unit" at the Lee County District Attorney's Office. Failure to comply by these financial policies and/or recurring instances of collection activity could result in dismissal from the practice.

I understand that some or all of my expenses at Auburn University Medical Clinic may not be covered by my health insurance. I understand and agree to pay all co-pays at the time of service. I also understand that after 60 days, any patient AND/OR insurance balance becomes my responsibility. If I choose to decline signing this document, I understand that a hold will be placed on my records for Graduation or Registration until all balances are paid in full. I agree that this agreement pertains to all visits to the Auburn University Medical Clinic. I acknowledge and understand that at all times I can receive a copy of my patient rights and responsibilities along with a privacy notice on the clinic's website and the patient portal. If I do not have internet access, I can receive a printed copy of the patient rights and responsibilities and privacy notice at the clinic.

Megann Queen
PATIENT SIGNATURE

7-29-14
DATE

MEDICAL INFORMATION FORM
AUBURN UNIVERSITY
(CONFIDENTIAL)

RECEIVED
JUL 29 2014
BY: _____

MEDICAL LEGAL DOCUMENT - Property of Auburn University Medical Clinic. Information may not be released to a third party unless a proper acceptable authorization is furnished to the Medical Clinic. This release must comply with State and Federal Regulations. Incomplete or inaccurate information may delay your clearance, cancel your registration, or cause improper decisions of your future medical care.

BEFORE YOU MAIL THIS FORM, be sure to COMPLETE BOTH SIDES...Sign...Have one of your Parents/Guardians Sign

MAIL, FAX or E-Mail TO:

Auburn University Medical Clinic
ATTN: Medical Records
400 Lem Morrison Drive
Auburn University, AL 36849-5349

Phone: (334) 844-4416
Fax: (334) 528-6780
E-Mail: aumcmrecords@eamc.org

365980

GENERAL INFORMATION

Name: Queen Meggan Lynn Taylor
Last First Middle
Home Address: 202 W Longleaf Apt 225A
City: Auburn
Date of Birth: 02/21/1996 Sex (circle one) M ☐ F ☒
Emergency Contact - Name: Robin Queen
Telephone: HOME: () - () - () WORK: () - () - ()
Address: 43 Lee Rd 2022 Phenix City AL 36867
Street / P.O. Box City State Zip
Social Security # 256-95-3181
AU User ID/GID 903637233
Student's Cell Phone: 334-614-6499
State: AL Zip: 36862
Auburn Email Address: m10001@auburn.edu
Relationship: Mother
CELLULAR: 334-614-0868
36867
Authorization for medical clinic to treat a minor student (under 19 years of age): Robin A. Queen
(Signature of parent or legal guardian)
List Allergies to medication or other items _____
Student Starting School: Fall, 2014
Semester Year

REQUIRED:

MEDICAL DOCUMENTATION

1. TUBERCULIN SKIN TEST (PPD): This is required within six (6) months prior to the first day of class of the semester you enter school. Having a chest x-ray is NOT an acceptable alternative unless otherwise stated in Appendix A. Anyone with a new or previous positive PPD test, please refer to Appendix A on this form.

Date PPD given: 7-29-2014 Date results read (must be no earlier than 48 hours and no later than 72 hours): 8-1-2014

Results of PPD (MUST BE DOCUMENTED IN MM - NO EXCEPTIONS) 0 mm

Documentation / Evaluation _____

M.D. Printed Name _____

&

M.D. Signature _____

PLEASE, DO NOT WRITE "Negative"

AUBURN UNIVERSITY MEDICAL CLINIC
400 LEM MORRISON DRIVE
AUBURN, AL 36849-5349

REQUIRED: A copy of an immunization record with your MMRs documented will be acceptable.

2. MEASLES: Measles vaccine, Live, Attenuated IS required if born after 1957. Last dose must be since 1990.
Date _____ Type (circle): MMR M M

M.D. Printed Name _____

&

M.D. Signature _____

CLINIC STAMP

*** (OPTIONAL) ***** (OPTIONAL) ***** (OPTIONAL) ***** (OPTIONAL) ***** (OPTIONAL) ***

3. Tetanus Toxoid - Date of last series or booster _____ 4. Meningococcal Meningitis Vaccine - Date _____
5. Hepatitis B Series - Dates of Series _____

In the event this documentation is not easily obtainable, all of the above services can be provided at the Auburn University Medical Clinic for a fee
Page 1