

Clinic: _____

Name: Kamesia Brown

Date of Birth: 12/19/71 Record #: _____

Allergies: _____ Reactions: _____

History of Chickenpox? YES or NO If yes, date if known: _____

Vaccine	Date Admin			Age at the time	VIS Form Given			Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr				
Td					Td			0.5cc		IM	
Td					Td			0.5cc		IM	
Td					Td			0.5cc		IM	
Td					Td			0.5cc		IM	
Tdap					Tdap			0.5cc		IM	
Hep B					Hep B					IM	
Hep B					Hep B					IM	
Hep B					Hep B					IM	
Hep B (booster if needed)					Hep B					IM	
MMR Rubella Rubeola					MMR			0.5cc		SQ	
MMR Rubella Rubeola					MMR			0.5cc		SQ	
Varicella					Var			0.5cc		SQ	
Varicella					Var			0.5cc		SQ	
IPV					Polio			0.5cc		SQ	
IPV					Polio			0.5cc		SQ	
IPV					Polio			0.5cc		SQ	
IPV					Polio			0.5cc		SQ	
PPV23					PPV			0.5cc		IM	
PPV23					PPV			0.5cc		IM	
Hepatitis A					Hep A					IM	
Hepatitis A					Hep A					IM	
HPV					HPV			0.5cc		IM	
HPV					HPV			0.5cc		IM	
HPV					HPV			0.5cc		IM	
Influenza					Flu			0.5cc		IM	
Influenza					Flu			0.5cc		IM	
Influenza					Flu			0.5cc		IM	
MCV4					Mening					IM	
MPSV4					Mening					SQ	

* Manufacturers: M= Merck; S = Sanofi Pasteur; W = Wyeth; G = GlaxoSmithKline

** Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm, LD = Left Deltoid, RD = Right Deltoid

*** VIS Language given, if not English: _____

[illegible][illegible][illegible][illegible]



Authorization for Immunization Services

2121 West Bullard Ave, Fresno, CA T:(559) 435-2800 F:(800) 262-2863

OCCU-MED

Applicant Name

Kamesia Brown

Employer

Vectrus

Clinic Information

Auburn University Montgomery
7461 East Drive
Montgomery, AL 36117
Phone: (334) 244-3281
Fax: (334) 244-3396

Social Security Number

xxx-xx-9128

Job Class

ADPE Technician I

Date of Birth

12/19/1971

Exam Type

Occu-VAX Stateside (Afghanistan)

Appointment Date/Time

2/5/2020 at 2:30 PM

Requested Immunizations

Administration of Immunizations should be restricted to the Immunizations listed below:

Immunization Name	Lot Number	Dose	Initials	Date Given
✓ Tetanus-Diphtheria and Pertussis (TDAP)	DC 924	0.5cc	AM	2/5/20
✓ Hepatitis A (TwinRix <u>not</u> authorized)	G 99 R4	1.0cc	AM	2/5/20
✓ MMR (Measles, Mumps & Rubella)	SO14807	0.5cc	AM	2/5/20
✓ Typhoid Vaccination - Injection	R1B 731M	0.5cc	AM	2/5/20
✓ Injectable Polio	PIE 701M	0.5cc	AM	2/5/20

Administration of immunizations and/or titers not specified above is **NOT AUTHORIZED**. An additional Immunization Authorization must be obtained prior to the administration of any immunizations not specified above.

- Occu-Med will not authorize or cover the cost of Rapid Schedule Twinrix.
- All follow-up immunizations are the responsibility of the patient unless explicitly authorized by Occu-Med in writing.

This authorization shall be valid until 2/19/2020

Once the immunizations requested have been administered, please insert the lot numbers, dosage, initials of medical personnel administering vaccines, and date vaccine given on this form and fax to Occu-Med at (800) 262-2863. This documentation will be utilized during the review of invoices and must include lot number, date of service, site of administration and immunizations administered. Payment will not be submitted without such documentation.

Should the patient request any immunizations not authorized through this document, it is vital that they be informed that those treatments will be at his/her own expense and are not required for deployment or by Occu-Med; therefore, immunizations not listed above will not be paid by Occu-Med.

AM = Any W-RV-BC

Submission Instructions

- Please call (559) 435-2800 x270 with any questions regarding the testing requested on this authorization
- Immediately fax results to (800) 262-2863 upon completion or alternatively email results to harvesting@occu-med.com

Created 2/4/2020 7:32:20 AM by agarcia

Bill Exam To

Occu-Med
Attn: Accounts Payable
2121 West Bullard Ave
Fresno, CA 93711
T: (559) 435-2800 x269
F: (559) 435-2520



Patient Social Security Number

419029128

AUTHORIZATION FOR RELEASE OF INFORMATION FROM MEDICAL RECORD

Record Subject
(Patient's Name)

Last Name First Name Middle Initial

Birthday or Age

Address

Street, City and State

Telephone Number

I, the undersigned, hereby authorize

Health Care or Health Services Provider

to provide from my medical record the information specified below to Occu-Med, Medical Director, 2121 West Bullard Avenue, Fresno, CA 93711 and

Name of Any Duly Authorized Representative(s)

for the purpose of evaluating health status in relation to specific essential job requirements.

I further authorize Occu-Med to provide this information from my medical record to duly authorized representatives of my employer, if requested.

The information supplied is to be restricted to

and/or

Medical Condition or Injury Specified

Time Period to be Covered

and/or

Other Type of Information Specified

Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

This authorization shall be valid until

Date

Signature

Social Security Number

Date

or

Personal Representative

Date

TRANSMISSION VERIFICATION REPORT

TIME : 02/05/2020 15:03
NAME : ALM
FAX : 3342443396
TEL :
SER.# : BROD8J659256

DATE, TIME	02/05 15:01
FAX NO./NAME	918002622863
DURATION	00:01:30
PAGE(S)	03
RESULT	OK
MODE	STANDARD

P.O. Box 244023
Montgomery, AL 36124
Phone: 334-244-3281
Fax: 334-244-3396



**AUBURN UNIVERSITY
AT MONTGOMERY**

STUDENT HEALTH SERVICES

To: Occumed Billing

From: Amy Morris

Fax: (559)435 2520

Pages: 2

Phone:

Date 2/5/2020

Re: Kamesia Brown

cc:

☐ Urgent

☒ For Review

☐ Please Comment

☐ Please Reply

☐ Please Recycle

Comments:

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Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME

Brown, Jamesia

DATE OF BIRTH

12/19/71
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.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex? <i>mandate info for</i>	☒	☐	☐
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? <i>hypertension</i>	☒	☐	☐
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? <i>currently on steroids</i>	☒	☐	☐
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

Jamesia Brown

DATE

2/9/2020

FORM REVIEWED BY

[Signature]

DATE

2/5/2020

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.

P.O. Box 244023
Montgomery, AL 36124
Phone: 334-244-3281
Fax: 334-244-3396



**AUBURN UNIVERSITY
AT MONTGOMERY**

STUDENT HEALTH SERVICES

To: Alexis @ occumed

From: Amy

Fax: (800) 262-2863

Pages: 3

Phone:

Date 2/5/2020

Re: Kamesia Brown

cc:

☐ Urgent

☒ For Review

☐ Please Comment

☐ Please Reply

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Comments:

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