



GOVT. OF TELANGANA

International Certificate of Vaccination

Certificat International de Vaccination

International Health Regulations

Reglement Sanitaire International

Issued to / Delivre a

ALURI ROHIT VENKAT ~~KUMAR~~

**Passport No. or Travel Document No.
Numero du passeport ou de la piece justificative**

7 4391860

**Directorate of Institute of Preventive Medicine
P.H. Labs & Food (Health) Administration,
Narayanaguda, Hyderabad.**

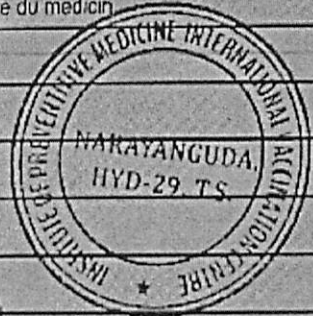
*Needs
TB skin test
Tdap*

OTHER VACCINATIONS / AUTRES VACCINATIONS

Date	Nature of Vaccine Genre de vaccin	Dose
	M. M. R Vaccine	
	B. No	
		

- 1 AUG 2018

Physician's signature
Signature du médecin



Ch. Lavanya 10/08/18

Dr. CH. LAVANYA
Civil Assistant Surgeon
Institute of Preventive Medicine
Narayanguda, Hyderabad

INTERNATIONAL CERTIFICATE OF VACCINATION OR
REVACCINATION AGAINST YELLOW FEVER

ALBERT ROHIT VENKAT KUMAR

This is to certify that / Je soussigné(e) certifie que

date of birth / né(e) le 03/09/2000

whose signature follows / dont la signature suit

A. Rohit Venkat Kumar

has on the date indicated been vaccinated against Yellow-fever

Date	Signature and professional status of vaccinator Signature of titre du vaccinateur
1	
2	
3	

4

CERTIFICAT INTERNATIONAL DE VACCINATION OU DE
REVACCINATION CONTRE LA FIEVRE JAUNE

sex / sexe M

a été vaccine (e) ou revaccine (e) contre la fièvre jaune
à la date indiquée

Manufacturer and batch no. of vaccine Fabricant du vaccin et numéro du lot	Official stamp of vaccinating centre Cachet officiel du centre de vaccination

5

RECEIVED

MEDICAL INFORMATION FORM
AUBURN UNIVERSITY
(CONFIDENTIAL)

MEDICAL INFORMATION FORM - 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 Phone: (334) 844-4416
ATTN: Medical Records Fax: (334) 528-6780
400 Lem Morrison Drive E-Mail: aumcmrecords@camc.org
Auburn University, AL 36849-5349

550420

GENERAL INFORMATION

Name: ALURI ROHIT VENKAT KUMAR Social Security # RVA0001
Last First Middle HYD AU User ID/GID
Home Address: P.NO-393, HNO:-3-6-25, VVNAGAR, KKP Student's Cell Phone: (+91)-9866314775
City: HYDERABAD State: TELANGANA Zip: 500072
Date of Birth: 03/09/2000 Sex (circle one) M F Auburn Email Address: RVA0001@auburn.edu
Emergency Contact Name: RAJ KASU Relationship: UNCLE
Telephone HOME: WORK: CELLULAR: (408)-569-0443
Address: 52, 53 CREEKSIDE LOOP HOOVER ALABAMA 35244
Street / P.O. Box City State Zip
Authorization for medical clinic to treat a minor student (under 19 years of age): A. Ratnakar
(Signature of parent or legal guardian)
List Allergies to medication or other items PPD & MMR
Student Starting School: FALL 1 2018
Semester Year

MEDICAL DOCUMENTATION

REQUIRED:

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 concerning Tuberculosis protocol.

Date PPD given: 28/06/2018 Date results read (must be no earlier than 48 hours and no later than 72 hours): 30/06/2018

Results of PPD (MUST BE DOCUMENTED IN MM - NO EXCEPTIONS!) 4 mm PLEASE, DO NOT WRITE "Negative"

Documentation / Evaluation

M.D. Printed Name

P.V. RATNAKAR

&

M.D. Signature

[Signature]

OR

Dr. P.V. RATNAKAR
Regd. No. 18438 M.D., (Ped)
CLINIC STAMP
Children Specialist
SVS CHILDREN HOSPITAL
MIG-243, Road No.4, KPHB Colony
Kukatpally, HYDERABAD - 500 072
Ph: 040 - 23052448

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 1980.

Date: 30/06/2018 Type (circle): MMR MR

M.D. Printed Name

P.V. RATNAKAR

&

M.D. Signature

[Signature]

OR

Dr. P.V. RATNAKAR
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*** (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

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

TELEPHONE: (334) 844-4416

FAX: (334) 528-6780

E-Mail: aumcmedrecords@eamc.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? _____
Subscriber# _____ Group # _____ Plan # _____
What is your insurance company's claims address _____
Who is the policy holder? _____ Gender: (circle one) M F
What is your relationship to the policy holder? _____ DOB of Policy Holder _____
Does your plan require a co-payment? _____ If so, how much? _____
What are the limits (age, full time status, etc.) on the policy for your coverage as a student? _____
Does your plan provide for "out of area" coverage for you? _____ Does your plan provide prescription benefits? _____

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): RAJ KASU
(First) (Middle) (Last)
Telephone #s Home: () - () - () Work: () - () - () Cellular: (408) - 569 - 0443
Address: 52.53 CREEKSIDE LOOP HOOVER ALABAMA 35244
(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.

A. Rohit Venkat Kumar
PATIENT SIGNATURE

27/06/2018
DATE



GOVERNMENT OF TELANGANA
DIRECTORATE OF INSTITUTE OF PREVENTIVE MEDICINE
PUBLIC HEALTH LABS & FOOD (HEALTH) ADMN. - HYDERABAD - 500 029, T.S.

MANTOUX TEST

Name: A Rohit Venkat Kumar
Age: 18 Sex: M
Registration No: 4212268 Date: 28/06/18
Results on: 30/06/18



Erythema and induration of 4 mm

Reading after 48/72 hrs- POSITIVE / NEGATIVE

Handwritten signature
30/6/18
MEDICAL OFFICER
Institute of Preventive Medicine
Narayanaguda, Hyderabad-28, T.S.