



This card should be carried at all times and is not transferable. Your Warhawk Access Card is permanent and valid as long as you are enrolled student or employee of the University. The card should be retained by students during semesters not enrolled for use when returning to school.

Report loss of card immediately to the ID Card Office (244-3555) or Campus Police (only when ID Card Office is closed). You will be responsible for all charges until the card is reported lost. A fee will be charged for replacement of a lost card.

AUM[®]

WARHAWK ACCESS



STUDENT

Rohit Venkat Kumar Aluri



TRANSMISSION VERIFICATION REPORT

TIME : 08/19/2020 09:54
NAME : AUM
FAX : 3342443396
TEL :
SER.# : BROD8J659256

DATE, TIME
FAX NO./NAME
DURATION
PAGE(S)
RESULT
MODE

08/19 09:48
9133452867809741319
00:06:03
09
OK
STANDARD
ECM

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



**AUBURN UNIVERSITY
AT MONTGOMERY**

STUDENT HEALTH SERVICES

Attn: Auburn University Medical Clinic

To:

From: AUM - Warhawk Health Services

Fax: 334-528-6780

Pages: 9

Phone:

Date 8/19/2020

Re: R. Aluri

cc:

☐ Urgent

☐ For Review

☐ Please Comment

☐ Please Reply

☐ Please Recycle

Comments:

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

**AUM Student Health Services
Immunization Record**

Patient Name: ROHIT ALURI

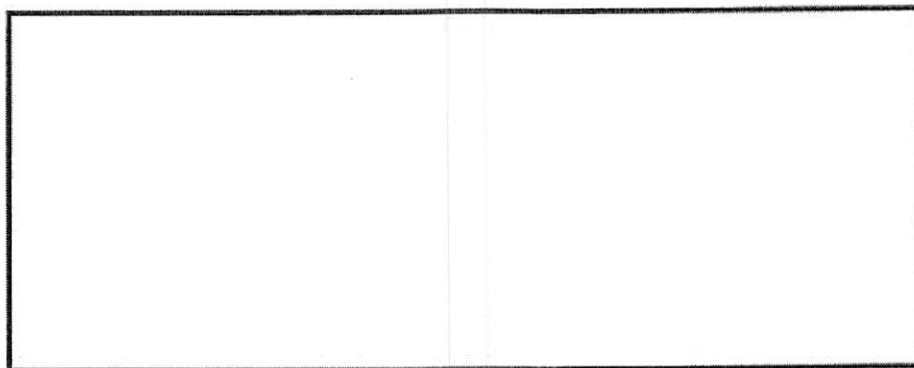
Birthdate: 09/03/2000

Allergies/Medical Alert:

Immunization	Date	Site	Dose	MFR	Comments	V.I.S.	Initials
Tdap	3/3/20	LD	0.5		LOT: DC924 EXP: 10/26/20 NDC 80984-43 Tdapax Inactivated, Reduced Diphtheria Toxin and Acellular Pertussis Vaccine, Adsorbed 0.5 mL 491018	2/15	AM
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	3/3/2020	3/5/20	18mm	SD	C5714AA	2/15/20 AM	KThy

Initials	Signature	Initials	Signature
AM	[Signature]		



STAMP ABOVE



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.**

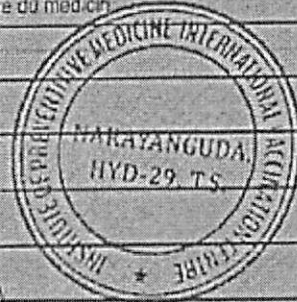
*Needs
TB skin test
Tdap*

OTHER VACCINATIONS / AUTRES VACCINATIONS

[illegible]

8

Physician's signature
Signature du médecin



ch. 17 01/08/18

Dr. CH. LAVANYA
Civil Assistant Surgeon
Institute Of Preventive Medicine
Narayana, Hyderabad

9

INTERNATIONAL CERTIFICATE OF VACCINATION OR
REVACCINATION AGAINST YELLOW FEVER

ALBERT ROHIT VENKAT KUMAR

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

date of birth / ne(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: aumcmedrecords@eamc.org
 Auburn University, AL 36849-5349

550920

GENERAL INFORMATION

Name: ALURI ROHIT VENKAT KUMAR Social Security # RVA0001
 Last First Middle Hyb AU User ID/GID RVA0001
 Home Address: P.NO-393, HNO:-3-6-25, VUNALUR, 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 HOOPER 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. [Stamp] 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
 Regd. No. [Stamp] M.D., (Ped)
CLINIC STAMP
 Children Specialist
SVS CHILDREN HOSPITAL
 MIG-243, Road No.4, KPHB Colony
 Kukatpally, HYDERABAD - 500 072
 Ph: 040 - 23052448

*** (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

DATA

27/05/2012

PATENT SIGNATURE

(Signature)

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-pay's at the time of service. I also understand that a bill will be placed on my record for Consultation or Registration until all balances are paid in full. I agree to make payments on my bill. I understand and 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.

Being Distinctive - If I have insurance, I understand balances will be filed with insurance companies under most circumstances. Funds 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. Notes may be placed on my report/credit report. Any outstanding balances are my responsibility. If my checks are returned, there will be a "returned debt" fee assessed for a minimum of \$30.00 and I may be referred to the "Northern Check Unit" at the Los County District Attorney's Office. Failure to comply by these financial policies under recurring failures of collection activity could result in dismissal from this practice.

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 with an interest in AUMC for payment of all or part of the charges pertaining to my Office Visit. 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.

Telephone No. _____ Home () _____ Work () _____
Collector (608) 569-0443
Address: 52.53, CAER ST OF 1000 HOOPER ALABAMA 35204 (City) (State) (Zip)

Patient's Relationship to Billing Person(s): ☒ Self ☐ Spouse ☐ Child ☐ Other ☒
 Name of Billing Person(s): RAJ (Last) KASU (First)

BILLING INFORMATION

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 cards, stating which is primary and which is secondary. We will also need each policy holder's name, date of birth, gender and relationship to the secondary insurance.

What is the name of your insurance company?
 Suburban
 Group 8
 Plan 8
 What is your insurance company's claims address
 Who is the policy holder?
 (Sender: check one) ☒ Me ☐ BOB or Policy Holder
 What is your relationship to the policy holder?
 Does your plan require co-payment?
 If so, how much?
 What are the funds (pvt, old time funds, etc.) on the policy for your coverage as a student?
 Does your plan provide the "out of area" coverage for you?
 Does your plan provide prescription benefits?

INSURANCE INFORMATION

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) 844-4016
WWW.AUBURN.EDMEDICAL

Hours of Operations

TELEPHONE: (839) 844-4416

FAX: (334) 528-6780

2-Mile extended records with

Auburn University Medical Clinic
406 Lerm Morrison Drive
Auburn University, AL 36849-5349



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: 42.12268 Date: 28/06/18
Results on: 30/06/18



Erythema and induration of 4 mm

Reading after 48/72 hrs. POSITIVE / NEGATIVE

30/6/18
MEDICAL SUPERVISOR
Institute of Preventive Medicine
Narayanaaguda, Hyderabad-29, T.S.