

ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: AUM

Name: Clement Johnson

Date of Birth: 7/20/93 Record #: _____

Allergies: NKA Reactions: _____

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

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf Abbr*	Lot Number	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	9	21	20		MMR	2	18			0.5cc	LA	SQ	AM
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	9	21	20		Hep A					1.0	LD	IM	AM
Hepatitis A					Hep A							IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
Influenza	9	21	20		Flu					0.5cc	RD	IM	AM
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: _____

Any in RW

TRANSMISSION VERIFICATION REPORT

TIME : 09/21/2020 09:47
NAME : AUM
FAX : 3342443396
TEL :
SER.# : BROD8J659256

DATE, TIME	09/21 09:46
FAX NO./NAME	918002622863
DURATION	00:01:08
PAGE(S)	02
RESULT	OK
MODE	STANDARD

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



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

FAXED
9/21/20

Attn:

To: Documed

From: Amy Morris

Fax: 800 262 2863

Pages: 2

Phone:

Date 9/21/20

Re: Clement Johnson

cc:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:

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Authorization for Immunization Services

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

OCCU-MED

Applicant Name

Clement Johnson

Employer

Vectrus

Clinic Information

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

Social Security Number

419-41-6518

Job Class

Inside/Outside Cable Plant Engineer Tech II

Exam Type

Occu-VAX Stateside (Qatar)

Appointment Date/Time

9/21/2020 at 9:30 AM

Requested Immunizations

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

Immunization Name

Lot Number

Dose

Initials Date Given

- ✓ Hepatitis A (TwinRix not authorized)
- ✓ Influenza - Injection
- ✓ MMR (Measles, Mumps & Rubella)

Q9GR4
N549A
5031483

1.0CC
0.5CC
0.5CC

AM 9/21/20
AM 9/21/20
AM 9/21/20

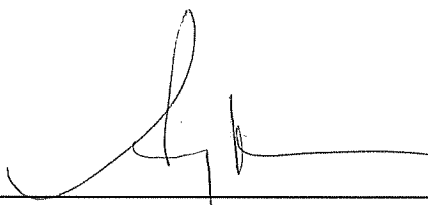
Administration of immunizations and/or titers not specified above is **NOT AUTHORIZED**. An additional Immunization Authorization must be obtained prior to the administration of any immunizations not specified above.

- * 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 10/5/2020

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.

 9/21/20

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 9/16/2020 12:34:16 PM 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

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Clement Johnson

DATE OF BIRTH 7/20/1993
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?	☐	☒	☐
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?	☐	☒	☐
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?	☐	☒	☐
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?	☐	☒	☐

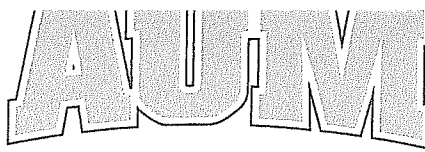
FORM COMPLETED BY Clement Johnson DATE 9-21-20

FORM REVIEWED BY [Signature] DATE 9/21/20

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.



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Clement Johnson DOB: 07/20/93 Phone: 334-201-6230

Mailing Address: 246 Osborne rd City: Lapine ST: AL Zip: 36046

Insurance Company: _____ Subscriber name: _____ DOB: _____

Insurance Contract Number: _____ Group number: _____

Screening Questions:	Yes	No	Don't Know
1) Are you sick today? (cold, fever, acute illness)	☐	☒	☐
2) Do you have allergies to any foods, medications or latex? (For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations) List _____	☐	☒	☐
3) Have you had any serious reactions from a vaccine?	☐	☒	☐
4) Have you been diagnosed with Guillain-Barre syndrome?	☐	☒	☐

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request,

Signature Clement Johnson Date 9-21-20

Administration Date 9/21/20 Route: IM LD or RD Volume: 0.5cc

Administrator [Signature] VIS Date 08/15/2019

Manufacturer: GSK Fluarix® Quadrivalent Lot # 9A235 Expires 06/30/2021

Temp: 97.7



OCCU-MED

Patient Social Security Number 419-41-6518

AUTHORIZATION FOR RELEASE OF INFORMATION FROM MEDICAL RECORD

Record Subject Johnson Clement D 27
(Patient's Name) Last Name First Name Middle Initial Birthday or Age

Address 246 Osborn Rd, Lapine, AL 334-201-6230
Street, City and State Telephone Number

I, the undersigned, hereby authorize AUM-STUDENT HEALTH CENTER
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 Clement Johnson 419-41-6518 9-21-20
Social Security Number Date

or _____
Personal Representative Date

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