

AUM Warhawk Health Services

Immunization Record

Patient Name: Khalif Chappell

Birthdate: 3/26/95

Allergies/Medical Alert: NKMA

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR							
HEP A	9/18/20	AD	1.0			✓	AM
HEP B							
Other	9/18/20	RD	0.5	SP	PIE 701M	✓	AM
	9/18/20	LD	0.5	ESK	QA 235	✓	AM

LOT: G99R4
EXP: 05/20/22

NDC 8160-826-43

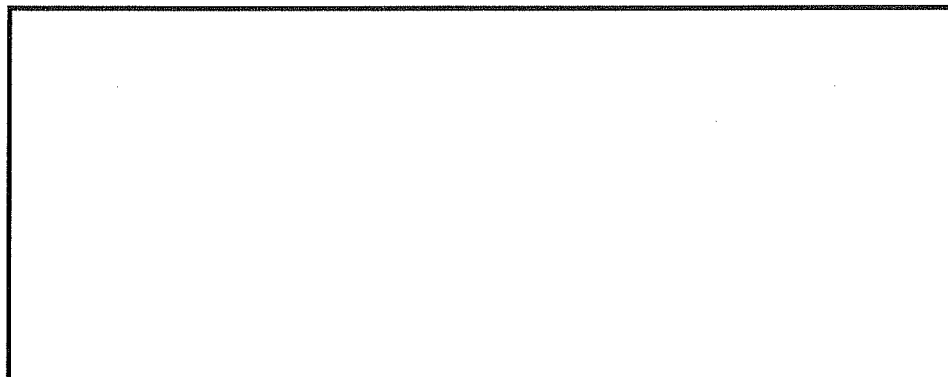
Hepatitis A
Vaccine
HAVRIX®

1440 EL.U./mL
Mfd. by
GlaxoSmithKline
Biologics
474192

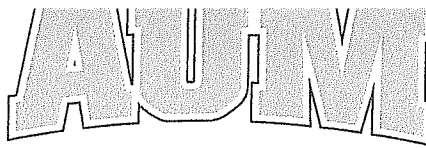
Polio
Flu

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials

Initials	Signature	Initials	Signature
AM	[Signature]		



STAMP ABOVE



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Khalif Chappell DOB: 03/26/1995 Phone: 334-549-6121

Mailing Address: 6225 County RD 10 City: Union Spring ST: AL Zip: 36089

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,

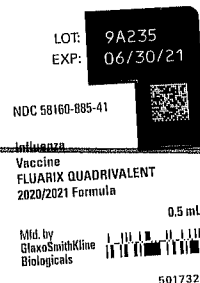
Signature: [Signature] Date: 09/18/20

Administration Date: 9/18/20 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: _____





OCCU-MED

Authorization for Immunization Services

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

Applicant Name

Khalif Chappell

Employer

IAP

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

XXX-XX-XXXX

Job Class

Ramp Operations Services

Exam Type

Occu-VAX Stateside (Afghanistan)

Appointment Date/Time

9/18/2020 at 8:30 AM

Requested Immunizations

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

Immunization Name

- ✓ Hepatitis A (TwinRix not authorized)
- ✓ Influenza - Injection
- ✓ Injectable Polio

Lot Number

G99 R4

98 9A 235

PIE701M

Dose

1.0cc

0.5cc

0.5cc

Initials

AM

AM

AM

Date Given

9/18/20

9/18/20

9/18/20

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 10/2/2020

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.

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 9/17/2020 8:17:26 AM by bmoore

Bill Exam To

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

**OCCU-MED**

2121 West Bullard Ave, Fresno, CA 93711

OCCUFAXDate: September 17,
2020**To****Auburn University Montgomery****Attention:** Amy**Phone:** (334) 244-3281**Fax:** (334) 244-3396**RE:** Vaccinations Scheduling for Khalif Chappell**From****Occu-Med****Name:** Brenna Moore**Phone:** (559) 435-2800 x192**Fax:** (559) 435-7200**E-Mail:** bmoore@occu-med.com**REMARKS:**☐ Urgent☐ For your review☐ Reply ASAP☐ Please comment

Khalif Chappell is scheduled for an immunization appointment on Friday, September 18, 2020 at 8:30 AM. Included with this fax is an authorization of services to be provided to this applicant on our behalf. If you have any questions, please feel free to contact me.

If you have any issues please contact Occu-Med at (559) 435-2800.

Thank you,

Brenna Moore

Confidentiality Notice

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



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

Attn: Brenna Moore

To: Occumed

From: Amy Morris

Fax: 559 435 7200

Pages: 20

Phone:

Date

9/18/20

Re: Khalif Chappell

cc:

☐ Urgent

☒ For Review

☐ Please Comment

☐ Please Reply

☐ Please Recycle

Comments:

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TRANSMISSION VERIFICATION REPORT

TIME : 09/18/2020 08:47
NAME : AUM
FAX : 3342443396
TEL :
SER.# : BR0D8J659256

DATE, TIME	09/18 08:46
FAX NO./NAME	8815594357200
DURATION	00:01:09
PAGE(S)	02
RESULT	OK
MODE	STANDARD

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Khalif Chappell

DATE OF BIRTH 03 / 26 / 1995
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? <u>Anthrax</u>	☐	☐	☐

FORM COMPLETED BY KHALIF CHAPPELL DATE 09/16/2020

FORM REVIEWED BY [Signature] DATE 9/18/20

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.