

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



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

Attn: Angela Coleman

To: Occumed

From: Amy Morris

Fax: 1800 262 2863

Pages: 2

Phone:

Date 9/30/20

Re: John Marshall

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.

ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: _____
 Name: John Marshall
 Date of Birth: 4/22/68 Record #: _____
 Allergies: NKMA 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				4F99G 08/19/22	0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Tdap	9	30	20		Tdap	2	15		0.5 mL	0.5cc	LD	IM	AM
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	9	30	20	8/18	Flu					0.5cc	LD	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: _____



OCCU-MED

Patient Social Security Number 417 19 2976

AUTHORIZATION FOR RELEASE OF INFORMATION FROM MEDICAL RECORD

Record Subject MARSHALL JOHN T 04/22/68
 (Patient's Name) Last Name First Name Middle Initial Birthday or Age
 Address 739 County Rd 165, Prattville, AL 334-221-2259
 Street, City and State Zip 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

Veronica MARSHALL
 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 9/30/21
 Date

Signature [Signature] 41719 2976 9/30/20
 Social Security Number Date

or _____
 Personal Representative Date

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME JOHN T. MARSHALL

DATE OF BIRTH 04 / 22 / 68
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 JOHN T. MARSHALL DATE 9/30/20

FORM REVIEWED BY [Signature] DATE 9/30/20

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.



OCCU-MED

Authorization for Immunization Services

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

Applicant Name

John Marshall

Employer

Textron Aviation Defense LLC

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-

Job Class

A&P Mechanic

Exam Type

Occu-VAX Stateside (Iraq)

Appointment Date/Time

9/30/2020 at 3:00 PM

Requested Immunizations

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

Immunization Name

- ✓ Tetanus-Diphtheria and Pertussis (TDAP)
- ✓ Typhoid Vaccination - Injection
- ✓ Influenza - Injection

Lot Number

4F99G

R1B73

N549A

Dose

0.5cc

0.5cc

0.5cc

Initials Date Given

AM 9/30/20

AM 9/30/20

AM 9/30/20

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 10/14/2020

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.

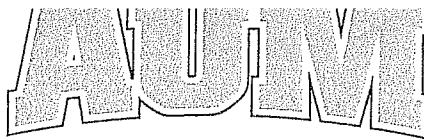
Submission Instructions

- 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

Bill Exam To

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

Created 9/28/2020 8:28:05 AM by argela.coleman



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: JOHN T. MARSHALL DOB: 4/22/68 Phone: 334 221 2259

Mailing Address: 739 County RD 165 City: Prattville ST: AL Zip: 36067

Insurance Company: _____ Subscriber name: _____ DOB: 4/22/68

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 9/30/20

Administration Date 9/30/20 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	Employer	Clinic Information
Clement Johnson	Vectrus	Auburn University Montgomery 7461 East Drive, Moore Hall Montgomery, AL 36117, United States Phone: (334) 244-3281 Fax: (334) 244-3396
Social Security Number	Job Class	
419-41-6518	Inside/Outside Cable Plant Engineer Tech II	
	Exam Type	Appointment Date/Time
	Occu-VAX Stateside (Qatar)	9/16/2020 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 <u>not</u> authorized)				
✓ Influenza - Injection				
✓ MMR (Measles, Mumps & Rubella)				

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.

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This authorization shall be valid until 9/30/2020

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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 9/15/2020 12:34:16 PM by agsrdia	Bill Exam To Occu-Med Attn: Accounts Payable 2121 West Bullard Ave Fresno, CA 93711 T: (559) 435-2800 x269 F: (559) 435-2520
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