

ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

Name: Kiara Jackson

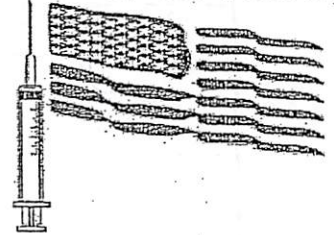
Date of birth: 11/26/1992 Record # _____

Allergies: NKA

Reactions: _____

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

Protect Our Future!



Immunize!

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	LOT: 5397F EXP: 12/06/21
Tdap	10	28	19		Tdap	2	15	Adacel® NDC 49281-400-58 (L) C5602AA (E) 19.MAR.2021		0.5cc	RD	IM	NDC 58160-821-43 Hepatitis B Vaccine (Recombinant)
Hep B	10	28	19		Hep B	7	16				RD	IM	ENGRIX-B® 20 mcg/mL Mfg. by GlaxoSmithKline Biologicals
Hep B					Hep B							IM	
Hep B												IM	
Hep B (booster if needed)												IM	
MMR Rubella Rubeola	1											SQ	
MMR Rubella Rubeola	10	28	19									LA	AM
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	10	28	19		Polio			SP	N.I.K.921M	0.5cc	RD	SQ	AM
PPV23					PPV					0.5cc		IM	
PPV23					PPV					0.5cc		IM	LOT: Y29KL EXP: 02/21/22
Hepatitis A	10	28	19		Hep A	7	16	GSK			LD	IM	NDC 58160-825-43 Hepatitis A Vaccine
Hepatitis A					Hep A							IM	HAVRIX®
HPV					HPV					0.5cc		IM	1440 FI U/mL Mfg. by GlaxoSmithKline Biologicals
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
Influenza	10	28	19		Flu			GSK3L32N		0.5cc	LD	IM	LOT: 3L32N EXP: 06/30/20
Influenza					Flu					0.5cc		IM	NDC 58160-896-41
Influenza					Flu					0.5cc		IM	Influenza Vaccine FLUARIX QUADRIVALENT 2019/2020 Formula
MCV4					Mening							IM	0.5 mL
MPSV4					Mening							SQ	Mfg. by GlaxoSmithKline Biologicals

* 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: _____

***Provider Information

[illegible]

Tuberculin Test

[illegible]

Titer Test Results for Non Susceptibility (IgM)

<u>Date</u>			<u>Disease</u>	☒ Results		<u>Notes</u>
<u>Mo</u>	<u>Day</u>	<u>Yr</u>		Neg	Pos	
	-					
	-					

[illegible]

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Kiara Jackson
DATE OF BIRTH 11 / 26 / 1992
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 Kiara Jackson DATE 10/28/19
FORM REVIEWED BY _____ DATE _____

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.



AUBURN

MONTGOMERY

Auburn University Student Health Services

TO: Alexis
COMPANY: Occumed
FAX NUMBER: 800-262-2863
PHONE NUMBER: _____
RE: Kiara Jackson

FROM: Amy Morris
DATE: 10/28/19
TOTAL PAGES, INCLUDING COVER: 3
SENDER'S REFERENCE NUMBER: 334 244 3281
CC: _____

☐ URGENT ☒ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY

NOTES/COMMENTS _____

The contents of this Fax message and any attachments are intended solely for the addressee(s) named in this message. This communication is intended to be and to remain confidential and may be subject to applicable attorney/client and/or work product privileges. If you are not the intended recipient of this message, or if this message has been addressed to you in error, please immediately alert the sender by fax and then destroy this message and its attachments. Do not deliver, distribute or copy this message and/or any attachments and if you are not the intended recipient, do not disclose the contents or take any action in reliance upon the information contained in this communication or any attachments.

P. O. Box 244023 Montgomery, AL 36124/ 334-244-3281 fax 334-244-3396



Patient Social Security Number 424-39-9854

AUTHORIZATION FOR RELEASE OF INFORMATION FROM MEDICAL RECORD

Record Subject Jackson Kura S 11/26/1992
(Patient's Name) Last Name First Name Middle Initial Birthday or Age
Address 3562 Berkley Dr Montg Al (334) 832-6496
Street, City and State Telephone Number

I, the undersigned, hereby authorize AUM- Student Health Services
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 _____

Medical Condition or Injury Specified and/or _____
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 _____

Signature Kura Jackson 424-39-9854 10/28/2019
Date Social Security Number Date

or _____
Personal Representative Date



Authorization for Immunization Services

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

OCCU-MED

Applicant Name

Kiara Jackson

Employer

Vectrus

Clinic Information

Auburn University Montgomery
7401 East Drive
Montgomery, AL 36117
Phone: (334) 244-3281
Fax: (334) 244-3396

Social Security Number

xxx-xx-9854

Job Class

ADPE Technician I

Date of Birth

11/26/1992

Exam Type

Occu-VAX Stateside (Afghanistan)

Appointment Date/Time

10/28/2019 at 9:00 AM

Requested Immunizations

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

Immunization Name	Lot Number	Dose	Initials	Date Given
✓ Tetanus-Diphtheria and Pertussis (TDAP)	C5602AA	0.5cc	BM	10/28/19
✓ Hepatitis A (TwinRix <u>not</u> authorized)	Y29KL	1.0cc	BM	10/28/19
✓ Hepatitis B (TwinRix <u>not</u> authorized)	5397F	1.0cc	BM	10/28/19
✓ MMR (Measles, Mumps & Rubella)	5010704	0.5cc	AM	10/28/19
✓ Typhoid Vaccination - Injection	PID631M	0.5cc	AM	10/28/19
✓ Influenza - Injection	3L32N	0.5cc	AM	10/28/19
✓ Injectable Polio	N1K921M	0.5cc	AM	10/28/19

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 11/11/2019

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 10/24/2019 1:28:54 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

TRANSMISSION VERIFICATION REPORT

TIME : 10/28/2019 10:16
NAME : AUM
FAX : 3342443396
TEL :
SER.# : BROD8J659256

DATE, TIME	10/28 10:15
FAX NO./NAME	918002622863
DURATION	00:01:06
PAGE(S)	02
RESULT	OK
MODE	STANDARD