

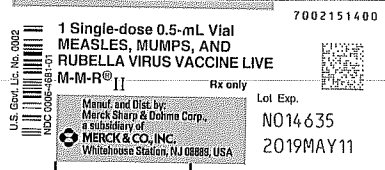
**AUM Student Health Services
Immunization Record**

Patient Name: Jiehang Song

Birthdate: _____

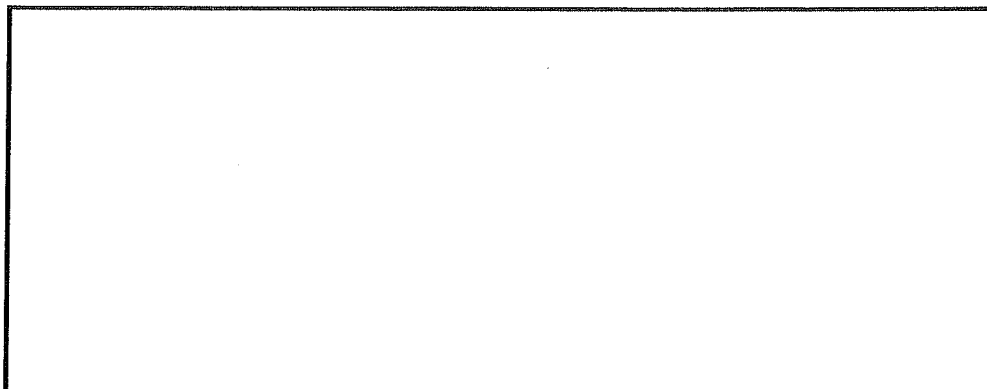
Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	Visit Date	Initials
Tdap	1/9/17	LD	0.5	Adacel® NDC 49281-400-58 (L) C 5243AA (E) 26, JUL. 2019		2/15	AM
Td Booster							
MMR	1/9/17	LA	0.5	Merck			AM
HEP A							
HEP B							
Other							



Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	1/5/18	1/9/18	0 MM SP		C5154AA	④ forearm	AM

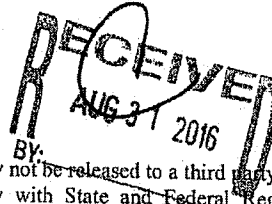
Initials	Signature	Initials	Signature



STAMP ABOVE

473200

MEDICAL INFORMATION FORM
AUBURN UNIVERSITY
(CONFIDENTIAL)



MEDICAL LEGAL DOCUMENT – 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 PAGES...Sign...Have one of your Parents/Guardians Sign

MAIL, FAX or E-Mail TO:

Auburn University Medical Clinic
ATTN: Medical Records
400 Lem Morrison Drive
Auburn University, AL 36849-5349

Phone: (334) 844-4416
Fax: (334) 528-6780

E-Mail: aumcmedrecords@eamc.org

473200

GENERAL INFORMATION

a03924816

Name: Song Jiehang Last First Middle Social Security # 003924816
Home Address: Fan Cheng Qu Wan Da Xiao Qu 9 hao lou 3202 AU User ID/GID JZS 0131
City: Xiang Yang, Hu Bei Student's Cell Phone:
Date of Birth: Feb 07, 1997 Sex (circle one) (M) F Auburn Email Address:
Emergency Contact – Name: Gu Guang Rong Relationship: Mother
Telephone #s HOME: (86) - (3807) - 8607 WORK: (704) - 877 - 5478 CELLULAR: (86) - 1330 - 728607
Address: Wan Da Xiao Qu 9 hao lou Xiang Yang Hu Bei 441000
Street / P.O. Box 3202 City State Zip
Authorization for medical clinic to treat a minor student (under 19 years of age): 2/ 孙芳 Gu Guang Rong
(Signature of parent or legal guardian)

List Allergies to medication or other items

Student Starting School: _____

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: 08/09/2016 Date results read (must be no earlier than 48 hours and no later than 72 hours): 08/11/2016

Results of PPD (MUST BE DOCUMENTED IN MM – NO EXCEPTIONS!) 5x5 mm

PLEASE, DO NOT WRITE

Documentation / Evaluation

M.D. Printed Name JIN HUA

&

M.D. Signature [Signature]

OR

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 Jul 05, 2016 / Jul 11, 2013 Type (circle): (MMR) MR M

M.D. Printed Name JIN HUA

&

M.D. Signature [Signature]

OR

*** (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

Auburn University Medical Clinic
400 Lem Morrison Drive
Auburn University, AL 36849-5349

TELEPHONE: (334) 844-4416
Hours of Operation:

FAX: (334) 528-6780
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)

E-Mail: aumcmrecords@camc.org

WWW.AUBURN.EDU/MEDICAL

INSURANCE INFORMATION

What is the name of your insurance company? _____
Subscriber# _____ Group # _____ Plan # _____
What is your insurance company's claims address _____
Who is the policy holder? _____ Gender: (circle one) M F
What is your relationship to the policy holder? _____ DOB of Policy Holder _____
Does your plan require a co-payment? _____ If so, how much? _____
What are the limits (age, full time status, etc.) on the policy for your coverage as a student? _____
Does your plan provide for "out of area" coverage for you? _____ Does your plan provide prescription benefits? _____

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

BILLING INFORMATION

Patient's Relationship to billing Person(s): Self ☒ Spouse ☐ Child ☐ Other ☐

Name of Billing Person(s): Jiehang _____ Song _____
(First) (Middle) (Last)

Telephone #s Home: (86) - (280) 727-8607 Work: (86) - (230) 727-8607 Cellular: () - _____

Address: Fancheng Ru Wan Da Xue Ru 98 hao Lou 1F, Xiang Yang Hu Bei 461000
(Street / P.O. Box) (City) (State) (Zip)

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 liable to AUMC for payment of all or part of the charges pertaining to my office visits. 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.

Billing Disclosure - If I have insurance, I understand balances will be filed with insurance companies under most circumstances. Items 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. Holds may be placed on my registration/graduation. Any outstanding balances are my responsibility. If any checks are returned, there will be a "returned check" fee assessed for a minimum of \$30.00 and I may be referred to the "Worthless Check Unit" at the Lee County District Attorney's Office. Failure to comply by these financial policies and/or recurring instances of collection activity could result in dismissal from the practice.

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-pays at the time of service. I also understand that after 60 days, any patient AND/OR insurance balance becomes my responsibility. You agree, in order for us to service your account or to collect monies you may owe, AUMC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable. If I choose to decline signing this document, I understand that a hold will be placed on my records for Graduation or Registration until all balances are paid in full. I 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.

PATIENT SIGNATURE

DATE

Immunization Record for JIEHANG SONG

Immunization Type	Immunization Order	Date	Medication	Funding	Comment
HPV #1	HPV9 (90651)	2/7/2017 3:29 PM	Gardasil 9	Private	
HPV #2	HPV9 (90651)	4/20/2017 1:39 PM	Gardasil 9	Private	
Human Papillomavirus 9-valent vaccine #1	HPV9 (90651)	2/7/2017 3:29 PM	Gardasil 9	Private	
Human Papillomavirus 9-valent vaccine #2	HPV9 (90651)	4/20/2017 1:39 PM	Gardasil 9	Private	
Tdap (7 years and up)	Tdap (7 years and up) (90715)	11/14/2016 1:14 PM	Adacel, 5-2-15.5LF-MCG/0.5	Private	

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
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 _____

DATE _____

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.