

Patient Name: Justin Felder

Allergies/Medical Alert: NKA

Immunization	Date	Site	Dose	MF	Comments	V.I. S.	Initials
Tdap	12/15/22	Upper Arm	1m		Lot #: X464C	8/16/21	WS
Td Booster							
MMR	12/15/22	Upper Arm Sub Q				8/16/21	WS
HEP A	12/15/22					10/15/21	WS
HEP B							
Other	12/15/22	Upper Arm Sub Q	0.5mL	1P01	Lot #: V2B891m	8/16/21	WS

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

Initials	Signature	Initials	Signature
URS	URS  JEN		

STAMP ABOVE



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Justin Felder DOB: 06/23/1989 Phone: 905 383 6216

Mailing Address: 187A Crossings Dr City: Millbrook ST: AL Zip: 36054

Insurance Company: Self 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,

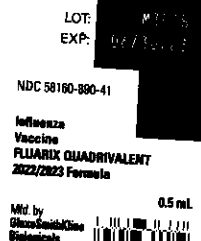
Signature Justin Felder Date 06/23/1989

Administration Date 12/5/2022 Route: IM LD or RD Volume: 0.5ml

Administrator m. Bicknell VIS Date 08/15/2019

Manufacturer: GSK Fluarix® Quadrivalent Lot # M3R5B Expires 06/30/2023

Temp: 98.9



Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Felder, Justin

DATE OF BIRTH 06 / 23 / 1989
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?	☐	☒	☐

typhoid - today to

(B) Dettol C weekly cleans

FORM COMPLETED BY

Justin Felder

DATE *05 DEC 22*

FORM REVIEWED BY

MR. J. J. J.

DATE *12/19/22*

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

Justin Felder

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

xxx-xx-4393

Job Class

Systems Administrator I

Exam Type

Occu-VAX Stateside (Iraq)

Appointment Date/Time

12/5/2022 at 8:00 AM

Authorized Immunizations

Administration of Immunizations is to be limited to the items listed below:

Immunization Name	Lot Number	Dosage	Initials	Date Given
✓ Tetanus-Diphtheria and Pertussis (TDAP)	X4646	0.5ml	WRS	12/9/2022
✓ Hepatitis A (TwinRix <u>not</u> authorized)	2BA99	1ml	WRS	12/9/2022
✓ MMR (Measles, Mumps & Rubella)	W009750	0.5ml	WRS	12/9/2022
✓ Influenza - Injection	m3R5B	0.5ml	WRS	12/9/2022
✓ Injectable Polio	V2B891m	0.5ml	WRS	12/9/2022

Administration of unauthorized immunizations and/or titers are **NOT AUTHORIZED**.

- 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 is valid until 12/19/2022. Once the immunizations requested have been administered, record 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. Payment will not be submitted without such documentation.

Should the patient request any immunizations not specifically 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



OCCU-MED

Social Security Number xxx-xx-4393

AUTHORIZATION FOR RELEASE OF INFORMATION FROM MEDICAL RECORD

Record Subject Felder, Justin 6/23/1989
Last Name First Name Middle Initial Birthday or Age

Address 1812 Crossings Drive Millbrook, AL 36054 (205) 383-6716
Street, City and State Telephone Number

I, the undersigned, hereby authorize Warhawk 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 Ave. 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 any person or entity.

This authorization shall be valid until _____
Date

Signature Justin Felder xxx-xx-4393 05 DEC 22
Social Security Number Date

or _____
Personal Representative Date