

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 4/13/18 Are you an AUM Student? ☒ Yes ☐ No S-Number: _____

Name: KAELEN A. BYROM Birthdate: 04/20/2006

Main Phone Number: 334-462-5420 Alternate Phone Number: 334-462-5421

Local Mailing Address: 9161 WHITE POPLAR CIRCLE Box or APT #: _____

City: PIKE ROAD State: AL Zip Code: 36064

Permanent/Home Address: SAME AS ABOVE Box or APT #: _____

City: _____ State: _____ Zip Code: _____

Marital Status (Please Circle): ☒ Single ☐ Married ☐ Divorced ☐ Widowed Other: _____

Sex (Please Circle): Male ☒ Female Gender: Male ☒ Female

Primary Physician: CATHERINE WOOD City: MONTGOMERY Phone #: 334-272-1799

Patient's Employer: STUDENT Work Phone #: _____

Parent's or Spouse's Name (Circle which): KIMBERLY B. BYROM Phone #: 334-462-5420

Parent's or Spouse's Employer: ALFA INSURANCE Phone #: 334-612-5116

Emergency Contact: KIMBERLY B. BYROM Relationship: MOTHER Phone #: 334-462-5420

How did you hear about the clinic (Circle which): Friend ☐ Faculty/Staff ☒ Orientation ☐ Other: _____

INSURANCE INFORMATION

Do you have health insurance? ☒ YES ☐ NO

If yes, please give your card to the front desk in order for a copy to be made for your chart.

Insurance Company: BC/BS Alabama Name on Card: KIMBERLY B. BYROM

Policy or Contract Number: KIU873166841 Group Number: 73920

Insurance Company's Address: BC/BS Alabama 450 RIVERCHASE PKWY E
BERMINGHAM AL 35244

AUM STUDENT HEALTH CENTER

CONSENT FOR SERVICES FORM

Patient Name: KAIDEN A. Byrom Date of Birth: 04 / 20 / 2006
Day Month Year

General Consent for Treatment

I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Kaiden Byrom
Signature of Patient

4 / 18 / 18
Day Month Year
Date of Signature

[Signature]
Signature of Legal Representative (if patient is unable to sign)

FATHER
Relationship to Patient

AUM Student Health Services
Medical Information Release Form
(HIPPA Release Form)

Name: KAIDEN A. BYROM Date of Birth 4/20/2006

Release of Information

☒ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

☐ Spouse: _____

☐ Child(ren): _____

☒ Other: KIMBERLY B. BYROM / CHARLES E. BYROM

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ☒ my home ☐ my work ☐ my cell number: (334)-462-5420

If unable to reach me:

☐ you may leave me a detailed message

☐ please leave a message asking me to return your call

☐ other: _____

The best time to reach me is (day or days) M-F between 7am and 7pm times.

Signed: Kaiden Byrom

Date: 4/13/2018


CHARLES E. BYROM (Father)

AUM Student Health Services

PATIENT HIPPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involve in my treatment)
- Obtaining payment from third party payers (e. g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this 13 day of APRIL 20 18.
(day) (month) (last two digits of the year)

Print Patient's Name: KAIDEN A. BYROM

Signature: _____

Relationship to Patient (if you are the patient, write "self"): _____


CHARLES E. BYROM (Father)

AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 4/13/2018 Name KAIKEN A. BYRON

1. What is the reason for your visit today IMMUNIZATION
2. List allergies you have to medicines, foods or iodine: N/A Unknown
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): N/A
4. Have you had any of the following: (circle if this applies to you);
Heart disease N
Kidney disease N
Stomach/Gastrointestinal disease N
Diabetes/sugar N
5. Are you immunocompromised? (Is there a problem with your immune system) Yes No X
Thymus disorder (Myasthenia gravis, thymoma, thymectomy) N
Spleen removed N
Transplant recipient N
Cirrhosis of the liver N
Cancer N
HIV N
6. How often do you drink beer, wine, wine cooler, or liquor? (Please circle)
Never / Rarely / 1-2 times a week / 3-4 times a week / 5 or more times a week
7. Where are you going on your trip? HAITI
8. How long is your trip? Months Days 7
9. When are you leaving on your trip? JUNE 2, 2018

FOR FEMALES ONLY

- A. Date of your last period? N/A Have you had a hysterectomy? YES NO X
- B. Are you currently pregnant? YES NO X
What is your due date?
- C. Do you plan to become pregnant in the next 3 months? YES NO X
- D. Are you breastfeeding? YES NO X

Clinic: _____

Name: Kaiden Byrom

Date of Birth: 4/20/06 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					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Tdap					Tdap					0.5cc		IM	
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					Flu					0.5cc		IM	
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: Over

[illegible][illegible][illegible][illegible]

Patient name:

Kaiden
Kimberly Byrom

of birth:

4 / 20 / 06
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child 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. Is the child sick today?	☐	☒	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☒
3. Has the child had a serious reaction to a vaccine in the past?	☐	☒	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☒	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☒	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☒	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☒	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐	☒	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? - Tamiflu 10/17	☒	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☒	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☒	☐

Form completed by:

Kimberly Byrom

Date:

4.13.2018

Form reviewed by:

[Signature]

Date:

4/13/18

Did you bring your child's immunization record card with you?

yes ☒ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

Technical content reviewed by the Centers for Disease Control and Prevention

IMMUNIZATION ACTION COALITION Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (1/15)

CPM-Immunization

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

AUBURN MONTGOMERY
STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023
(334) 244-3281

Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

Darlene Pierce, C.R.N.P.
Lic. #1-134315
RX: 3692

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Name Jameson Byrom Date 4/13/18
Address _____

Rx

Aralen 400mg 500mg

Disp: 7

Sig: Take one pill every 7 days. Begin 2 wks before
departure, continue through stay and
for four weeks after return.

Label all prescriptions

Refill: 1 2 3 5 PRN NR

M. Fuentes, CRNP
Product Selection Permitted

M.D. or C.R.N.P.

Dispense As Written

M.D. or C.R.N.P.

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

AUBURN MONTGOMERY
STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023
(334) 244-3281

Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

Darlene Pierce, C.R.N.P.
Lic. #1-134315
RX: 3692

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Name Kaiden Byrom Date 4/13/18
Address _____

Rx

Aralen 400mg 500mg

Disp: 7

Sig: Take one pill every 7 days. Begin 2 wks before
departure, continue through stay and
for four weeks after return.

Label all prescriptions

Refill: 1 2 3 5 PRN NR

M. Fuentes, CRNP
Product Selection Permitted

M.D. or C.R.N.P.

Dispense As Written

M.D. or C.R.N.P.