DIRECTIONS FOR THE MEDICAL FORM Both pages must be completely filled out.

- 1. Fill out the form **COMPLETELY** before turning it in or it will be returned to you. An incomplete form **may keep students from registering** for classes.
- 2. You **MUST** put the student's complete social security number on the form.
- 3. The two **REQUIRED** immunizations/tests are:
 - -TUBERCULIN SKIN TEST (PPD)
 - -MEASLES (MMR)

See the form for specifications

- *we do NOT require a physical*
- *all other immunizations/tests are optional*
- 4. The doctor **MUST** sign and print his/her name **OR** a clinic stamp **MUST** be present for the immunizations/tests. (Records with the clinic stamp or Doctor's signature are acceptable as long as a copy is included with the form)

a copy of the insurance card front and back should also be included

THE STUDENT MUST SIGN THE BOTTOM OF PAGE TWO OF TWO ABOVE PATIENT SIGNATURE.

The forms may be FAXED, MAILED, scanned and E-MAILED or HAND DELIVERED. The address and fax number are on the top of the form, page one of two.

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

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

FAX: (334) 528-6780

E-Mail: aumcmedrecords@eamc.org

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)

To Make an Appointment: Please Call (334) 844-4416

WWW.AUBURN.EDU/MEDICAL

INSURANCE INFORMATION

What is the name of	of your insurance	e company?							
Subscriber#		Gro	oup #		Plan #				
What is your insura	rance company's	claims address							
				Gender: (circle one) M F					
What is your relationship to the policy holder?				DOB of Policy Holder					
Does your plan req	quire a co-payme	ent?	If so, how m	ruch?					
	-	_		-					
Does your plan pro	ovide for "out of	f area" coverage for	you?Do	oes your plan provide	prescription benefits?_				
provide both o	clearly statin	ng which is prin					rance coverage, pl er's name, date of		
			BIL	LING INFORM	ATION				
Patient's Relation	onship to billi	ng Person(s):	Self	Spouse	Child	_ Other			
Name of Billing	Person(s)	(First)		(Middle)	(Last)				
Telephone #s	Home:	-	Work:	: -	Cellula	ar:	-		
Address									
(Street / P.O. Box)				(City)		(State)	(Zip)		
insurance compa AUMC to act as payments sent to	any, employer, as my agent w o me will be p	or any other persy then filing insurant promptly forwarde	sons liable to AUM nce claims on my	IC for payment of al behalf. I directly derstand that I am r	l or part of the charg assign to AUMC a	ges pertaining to ll insurance ben	be required or reque my office visits. I al efits and agree that a at the Auburn Univers	so authorize any benefits	
otherwise accound be collected throod Any outstanding and I may be r	nted for by an ough a collection g balances are referred to the	insurance compar on agency includi e my responsibili e "Worthless Ch	ny will be billed to ng any additional c ity. If any checks leck Unit" at the I	me or my designate costs related to the co are returned, there	d responsible party. ollection process. H e will be a "returne et Attorney's Office	After a period olds may be placed check" fee as	mstances. Items not for time, uncollected be ged on my registration assessed for a minimum mply by these finance.	alances may n/graduation. m of \$30.00	
pay all co-pays a decline signing to that this agreeme my patient right	at the time of sections to this document, ent pertains to the section and responsible to the section at the section and responsible to the section at the se	ervice. I also und I understand that all visits to the Au sibilities along w	lerstand that after 60 a hold will be place uburn University M vith a privacy notice	0 days, any patient A ed on my records for Jedical Clinic. I ack	AND/OR insurance r Graduation or Reg nowledge and undo ebsite and the patic	balance become istration until all erstand that at a	nce. I understand and s my responsibility. If balances are paid in fall times I can receive o not have internet a	I choose to full. I agree e a copy of	
PATIENT SIG	GNATURE					DATE			

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 SIDES...Sign...Have one of Your Parents Sign

Auburn University Medical Clinic

ATTN: Medical Records

Phone: (334) 844-4416

Fax: (334) 528-6780

MAIL, FAX or E-Mail TO:

Clinic for a fee.)

400 Lem Morrison Drive E-Mail: aumcmedrecords@eamc.org Auburn University, AL 36849-5349 **GENERAL INFORMATION** — Social Security # —— Name: -First Middle AU User ID/GID Home Address ____ _Student's Cell Phone___ Zip____ Sex (circle one) M F Email Address Relationship Emergency Contact – Name _____ WORK CELLULAR Telephone #s HOME_____ Address Street / P.O. Box City Authorization for medical clinic to treat a minor student (under 19 years of age)— (Signature of parent or legal guardian) List Allergies to medication or other items ____ Semester entering school (Semester / Year) MEDICAL DOCUMENTATION **REOUIRED:** 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 you previously had a positive PPD test. Anyone with a new or previous positive PPD test, according to Alabama Public Health Department guidelines, must provide the chest x-ray films AND an official report to AUMC. If you have initiated or completed medical treatment for your positive PPD, then please provide the documentation to us. Date results read (must be no earlier than 48 hours and no later than 72 hours): Date PPD given: Results of PPD (MUST BE DOCUMENTED IN MM – NO EXCEPTIONS!) mm PLEASE, DO NOT WRITE "Negative" Chest x-ray results Documentation / Evaluation _____ M.D. Printed Name CLINIC STAMP & OR **REQUIRED:** A copy of an immunization record with your MMRs documented will be acceptable. Measles vaccine, Live, Attenuated IS required if born after 1957. Last dose must be since 1980. 2. MEASLES: Type (circle): MMR Date -M.D. Printed Name CLINIC STAMP OR M.D. Signature____ ***(OPTIONAL)******(OPTIONAL)*****(OPTIONAL)*****(OPTIONAL)**** 3. Tetanus Toxid – Date of last series or booster Meningococcal Meningitis Vaccine – Date **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