

# Auburn University Montgomery

## Student Immunization Form

Immunization history must be completed and signed by a health care provider. Copies of your original immunization records are acceptable in place of this form, but **must be in English**. Please submit completed form or a copy of your immunization record to Warhawk Health Services.

Complete and Return to: **Warhawk Health Services**  
**Attn: Immunizations**  
**PO Box 244023**  
**Montgomery, AL 36124**  
**(334) 244-3281 Fax (334) 244-3396**

Name \_\_\_\_\_ Student Number \_\_\_\_\_  
*Last First Middle*

Address \_\_\_\_\_  
*Street City State Zip Code*

Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Enrollment \_\_\_\_\_

### REQUIRED IMMUNIZATIONS

**Tuberculosis Screening-** TB skin test must be performed within 2 months of matriculation.

Date Given: \_\_\_\_\_ Date Read: \_\_\_\_\_ Results: Positive \_\_\_\_\_ mm Negative \_\_\_\_\_ mm

If positive, you **must attach** a radiology report from chest X-ray **and** documentation of treatment.

\*All TB skin test, blood, and/or CXR must be performed in the U.S.

**Tdap-** Tetanus, Diphtheria, Pertussis - Students should have one adult dose within the last 10 years. If more than 10 years, then a booster is required.

Date of **Tdap** vaccine: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

### Measles, Mumps, Rubella (MMR)

Auburn Montgomery University requires that all students born after 1956 must have had 2 doses of a measles containing vaccine (MMR) prior to registration. One dose must have been after 1980. Lab antibody titers (IgG) for Measles, Mumps and Rubella are acceptable. (Please attach documentation to the back of the form).

Date of First Dose \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date of Second Dose \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

### RECOMMENDED IMMUNIZATIONS

These immunizations are not required by the university but are recommended by the American College Health Association.

**Hepatitis B:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*1st 2nd 3rd*

**Varicella (Chickenpox) Vaccine:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*1st 2nd*

**Meningococcal (MenACWY) Vaccine:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (One dose on or after the 16<sup>th</sup> birthday)  
*1st 2nd*

**Meningococcal B Vaccine** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

I certify that the above dates and vaccinations are true.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      \_\_\_\_\_  
**Signature of Licensed Health Care Professional**      **Date**      **License Number or Office Stamp**