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 16th 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**

(Adopted 1/12, Revised 5/2021)