Immunization Form

To ensure the health and safety of our campus, immunizations against communicable diseases is extremely important. Vaccination against Measles, Mumps, Rubella (MMR), Tetanus, Diphtheria and Pertussis, and proof of negative Tuberculosis is required of all students entering Auburn Montgomery. This form must be completed and is the preferred document for proof of immunizations and TB testing.

Complete and Return to: Student Health Center
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 Cell Phone Number E-mail Address Date of Birth

REQUIRED IMMUNIZATIONS

Tuberculosis Screening (within 6 months prior to semester student is to begin at AUM.)
Date Given_____ (Date of reading, within 48 to 72 hours of date given) TB skin test (PPD)_____/_____/_____

Results: Positive_____mm Negative _____ mm
If positive, you must attach a radiology report from chest X-ray and documentation of treatment.

Tetanus, Diphtheria, Pertussis Vaccine (preferred). Students without previous documentation of a TDaP vaccine should have one dose prior to entrance based on current guidelines. Other students should be current to maintain their status throughout their entire academic career.
Date of **TDaP** vaccine: _____/_____/_____
or Td _____/_____/_____(within the last 5 years)

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_____/_____/_____

OPTIONAL 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 (meningitis) Vaccine: _____/_____/_____ _____/_____/_____ **(MCV4 preferred)**
1st *2nd*

I certify that the above dates and vaccinations are true.

_____ _____/_____/_____ _____
Signature of License Health Care professional **Date** **License Number or Office Stamp**

(Adopted 1/12, Revised 8/2012)