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 (Tdap), 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_________________________

Address_________________________Street_________________________

First Middle Last

City________State____Zip Code__________

Phone Number________E-mail Address________Date of Birth________Date of Enrollment____

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 (Tdap) Vaccine—Students without previous documentation of a Tdap vaccine should have one dose within the last 10 years. Other students should be current to maintain their status throughout their entire academic career.
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________/_______/_______

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 (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 8/2016)