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: _______/______/_______ _______/______/_______

1st 2nd (One dose on or after the 16th birthday)

Meningococcal B Vaccine _______/______/_______

I certify that the above dates and vaccinations are true.

Signature of Licensed Health Care Professional _______/______/_______ License Number or Office Stamp

(Adopted 1/12, Revised 5/2021)