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 ___________________________

Last First Middle

Street 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 (titer) 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)