# 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*

Address_____
*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 (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)