

Immunization (Vaccination) Form

To ensure the health and safety of our campus, immunizations against communicable diseases are extremely important. Vaccination against Measles, Mumps, Rubella (MMR) and Tetanus, Diphtheria and Pertussis is required of all students entering Auburn University at Montgomery. This form must be completed and is the preferred document for proof of immunizations. Take this form to a doctor or clinic to be completed. Also, upon arrival to the campus, international students will be required to report to Student Health Services to receive a Tuberculosis Skin Test. The cost of this test is \$10.00. TB skin tests performed outside of the United States will not be accepted.

Name ALCOAER IBARHEM M AUM Student Number _____
Last First Middle

Local Address _____
Street City State Zip Code

Cell Phone Number _____ E-mail Address _____ Date of Birth (MMDD/YYYY) _____

REQUIRED IMMUNIZATIONS (Vaccinations)

Tetanus, Diphtheria, Pertussis Vaccine (preferred). Students without previous documentation of a TDaP vaccine should have one dose prior to entrance based on current guidelines. A DTaP will not be accepted.

Date of Tdap vaccine: 7 / 3 / 1997 (within the last 5 years).
D M Y

Measles, Mumps, Rubella (MMR) 2 separate vaccinations of the MMR, given at least 1 month apart is required.

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 4 / 4 / 1992 Date of Second Dose 5 / 6 / 2015
D M Y D M Y

OPTIONAL IMMUNIZATIONS (These immunizations are not required by the university but are recommended by the American College Health Association.)

Hepatitis B: 2 / 7 / 2015 2 / 8 / 2015 3 / 1 / 2016
1st 2nd 3rd

Varicella (Chickenpox) Vaccine: 7 / 3 / 1997 5 / 4 / 2015
1st 2nd

Meningococcal (meningitis) Vaccine: 4 / 5 / 2011 5 / 7 / 2017 (MCV4 preferred)
1st 2nd

I certify that the above dates and vaccinations are true.

Signature of Licensed Health Care professional [Signature] Date 7 / 2017
License Number or Office Stamp [Stamp]

