

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, 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 PHAM THAO PHUC MINH Student Number _____
Last First Middle
Address 365/5 Chu Van An Ward 12 Binh Thanh Dist. Ho Chi Minh city Vietnam
Street City State Zip Code
Phone Number _____ Cell Phone Number 01628583535 E-mail Address tinapham674@gmail.com Date of Birth 09/11/1998

REQUIRED IMMUNIZATIONS

Tuberculosis Screening (within 6 months prior to semester student is to begin at AUM.)

Date Given 15/12/17 (Date of reading, within 48 to 72 hours of date given) TB skin test (PPD) 18 / 12 / 17

Results: Positive 09 mm Negative _____ mm

If positive, you must attach a radiology report from chest X-ray and documentation of treatment.

Tetanus, Diphtheria, Pertussis Vaccine (preferred). Students without previous documentation of a TDaP vaccine should have one dose prior to entrance based on current guidelines. Other students should be current to maintain their status throughout their entire academic career.

Date of TDaP vaccine: 15 / 12 / 2017
or Td _____ / _____ / _____ (within the last 5 years)

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 18/12/2017 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: 18 / 12 / 2017 : _____ / _____ / _____
1st 2nd 3rd

Varicella (Chickenpox) Vaccine: _____ / _____ / _____
1st 2nd

Meningococcal (meningitis) Vaccine: 15 / 12 / 2017 _____ / _____ / _____ (MCV4 preferred)
1st 2nd

I certify that the above dates and vaccinations are true.



Signature of License Health Care professional CAM NANG Date 18 / 12 / 2017 License Number or Office Stamp 003281 - HCM / CCHN
(Adopted 1/12, Revised 8/2012)

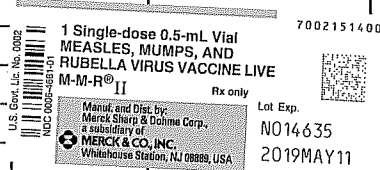
**AUM Student Health Services
Immunization Record**

Patient Name: Pham Phuc Minh Thao

Birthdate: 11/9/1998

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	Visit Date	Initials
Tdap							
Td Booster							
MMR	1/19/18	LA	0.5				AM
HEP A							
HEP B							
Other							



	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	1/5/18	1/8/17	Neg 0.00	SP	CS154AA	(D) forearm	AM

Initials	Signature	Initials	Signature

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023

STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME PHAM PHUC MINH THAO

DATE OF BIRTH 11/09/1998
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☒	☐	☐

FORM COMPLETED BY PHAM PHUC MINH THAO DATE 01/05/2018

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☒ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.