

Immunization (Vaccination) Form

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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 BOILEDULA DESHICA AUM Student Number 500348027
Last First Middle

Local Address Prakash Plot NO 131, H.NO 9-17/B, Ravindra nagar 4th, Habshiguda,
Hyderabad, Andhra Pradesh, India - 500007 City State Zip Code

+91 9581400777 deshicabolladula96@gmail.com 03/31/1996

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: 16 / 12 / 2017 (within the last 5 years).

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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 16 / 12 / 2013
D M Y

Date of Second Dose _____ / _____ / _____
D M Y

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

Hepatitis B: _____ / _____ / _____
 1st *2nd* *3rd*

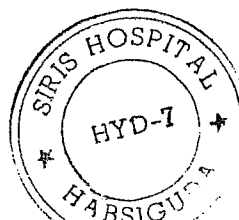
Varicella (Chickenpox) Vaccine: _____ / _____ / _____ _____ / _____ / _____
 1st *2nd*

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

I certify that the above dates and vaccinations are true.

Signature of License Health Care professional _____ Date 16/12/2017 _____ License Number or Office Stamp _____

Dr. D. Mohan Rao,
M.B.B.S; D.C.F
REGD. No: 7258



INTERNATIONAL CERTIFICATE OF VACCINATION OR
REVACCINATION AGAINST YELLOW FEVER

BALLEDLA DESHICA

This is to certify that / Je soussigne(e) certifie que

date of birth / ne(e) le

31 March 1996

whose signature follows / dont la signature suit

Deshica

has on the date indicated been vaccinated or revaccinated against
Yellow-fever

Date	Signature and professional status of vaccinator Signature of titre du vaccinateur
1	
2	
3	

CERTIFICAT INTERNATIONAL DE VACCINATION OU DE
REVACCINATION CONTRE LA FIEVRE JAUNE

sex / sexe

F

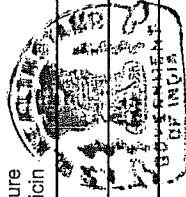
a été vaccine (e) ou revaccine (e) contre la fièvre jaune
à la date indiquée

Manufacturer and batch no. of vaccine Fabricant du vaccin et numéro du lot	Official stamp of vaccinating centre Cachet officiel du centre de vaccination

OTHER VACCINATIONS / AUTRES VACCINATIONS

Date	Nature of Vaccine Genre de vaccin	Dose
	MMR Vaccine	
	PRIORIX	
16 DEC 2017	Measles, Mumps and Rubella Vaccine (MMR) Priorix Lot: XHJRD40041 07/16 06/18 600.00	
	Tdap Vaccine	
	BOOSTRIX	
	BN01-AC3713 268 AC	
	(0.5ml)	

Physician's signature
Signature du médecin



Dr. Ch. Prabhakar

DEPUTY CIVIL SURGEON
Institute of Preventive Medicine
Marayanaguda, Hyderabad.

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Deshica Bolledula
DATE OF BIRTH 03/31/1996
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.

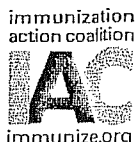
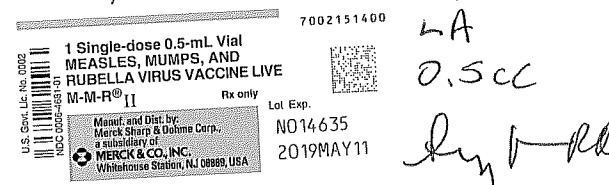
	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, 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 Deshica DATE 01/30/18

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.



Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunize.org/catg.d/p4065.pdf • Item #P4065 (8/17)

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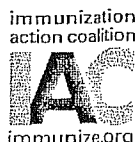
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