

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 PATHAK SHUBHAM RAJESH Student Number _____
Last First Middle
Address A/31 YONGERAT D-PLET OPP KUNTVILLA LATMIPURA, GORWA
Street City State Zip Code 35002
8511031001 shubhampathaksp21@gmail.com 11/17/1999
Phone Number Cell Phone Number E-mail Address Date of Birth

REQUIRED IMMUNIZATIONS

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

Date Given 12-16-17 Date of reading, within 48 to 72 hours of date given) TB skin test (PPD) 12/18/17

Results: Positive _____ mm Negative 2 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: 12/21/2017
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 12/21/2017 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: _____ / _____ / _____
1st 2nd 3rd

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

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

I certify that the above dates and vaccinations are true.

DR. MANESH C. PATEL
Reg No. G-5569 M.B. D.PED
Consulting Paediatrician 12/21/2017
Signature of Licensed Health Care Professional Date License Number or Office Stamp
Opp. Vardhman Complex
Subhannura Main Road, BARC
(Adopted 1/12, Revised 8/2012)