

Auburn University Montgomery

Student Immunization Form

Immunization history must be completed and signed by a health care provider. Copies of your original immunization records are acceptable in place of this form, but **must be in English**. Please submit completed form or a copy of your immunization record to Warhawk Health Services.

Complete and Return to: **Warhawk Health Services**
Attn: Immunizations
PO Box 244023
Montgomery, AL 36124
(334) 244-3281 Fax (334) 244-3396

Name Divan Arinash Vinod Kumar Student Number 500391633
Last First Middle
Address 4, New Menohar Park Society, Zulfikar Road, Ahmedabad, Gujarat, 380021
Street City State Zip Code
Phone Number +91 9033586904 E-mail Address Aridivan28@gmail.com Date of Birth 28/05/1995 Date of Enrollment 16/08/2021

REQUIRED IMMUNIZATIONS

Tuberculosis Screening- TB skin test must be performed within 2 months of matriculation.

Date Given: _____ Date Read: _____ Results: Positive _____ mm Negative _____ mm

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

*All TB skin test, blood, and/or CXR must be performed in the U.S.

Tdap- Tetanus, Diphtheria, Pertussis - Students should have one adult dose within the last 10 years. If more than 10 years, then a booster is required.

Date of Tdap vaccine: 06/07/21

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 21/07/21 Date of Second Dose 02/08/2021

RECOMMENDED 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.

Dr. YOGESH K. SHAH
B.H.M.S.

Reg. No G-3263
Signature of Licensed Health Care Professional
Opp. C.P. Nagar,
Ghathodia, Ahmedabad-61

02/08/21
Date

G-3263
License Number or Office Stamp

(Adopted 1/12, Revised 5/2021)