

## 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 \$15.00. TB skin tests performed outside of the United States will not be accepted.

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Last First Middle

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+1 603-405-8455 SOMASHEKAR8855@gmail.com 04/22/1996  
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: 17 / 06 / 21 (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 17 / 06 / 21  
D M Y

Date of Second Dose 22 / 07 / 2021  
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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (MCV4 preferred)  
1st 2nd

I certify that the above dates and vaccinations are true.



Signature of Licensed Health Care professional

Date

License Number or Office