

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 POTHULA TEJDEEP REDDY Student Number _____
Last First Middle
Address _____
Street City State Zip Code
Phone Number 810 680 3 627 E-mail Address Tejdeep.Reddy35@AUMontgomery.edu Date of Birth 07 / 11 / 2000 Date of Enrollment _____

REQUIRED IMMUNIZATIONS

Tuberculosis Screening- TB skin test must be performed within 2 months of matriculation. not done

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: 15 / 12 / 2021

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 15 / 12 / 2021 Date of Second Dose _____ / _____ / _____

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.

[Signature]

Signature of Licensed Health Care Professional

20 / 12 / 2020

Date

Dr. D. Mohan Rao

M.B.B.S, D.C

License Number or Office Stamp