

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 BOPPANAPALLI NARENDRA Student Number 500425099
Last First Middle
Address ADAVINEKKALAM VITAYAWADA ANDHRA PRADESH 521212
Street City State Zip Code

+917780329416 nayendraboppanapalli 28/04/1998 / /
Phone Number E-mail Address Date of Birth Date of Enrollment

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: 28/10/2020

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 15/02/1999 Date of Second Dose 18/02/2000

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: _____
1st 2nd (One dose on or after the 16th birthday)

Meningococcal B Vaccine _____

I certify that the above dates and vaccinations are true. **Dr. David Raj Baki**
M.B.S, Dip in Diabetology, FCC

Reg.No:84236
General Physician, Diabetologist

Signature
Signature of Licensed Health Care Professional

/
Date

/
License Number or Office Stamp