University of Miami School of Nursing
Immunization Form

I. TO BE COMPLETED BY STUDENT (please print)

Name ___________________                     Entering UM: Fall ___ Spring ___ Summer ___ Yr___
 Last,                     First               M. I.
UM Student # _______________________________ Date of Birth   month day year

II. TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

MEASLES, MUMPS AND RUBELLA IMMUNIZATION, OR LAB EVIDENCE OF IMMUNITY.
1) Two doses of MMR or Serologic proof of immunity to measles, mumps and rubella

MMR dose #1
(month day year) (after age 12 months, and in 1968 or later)

dose #2
(month day year) (at least 28 days after dose #1)

Measles immunity
(month day year) (lab result must be provided)

Rubella immunity
(month day year) (lab result must be provided)

Mumps immunity
(month day year) (lab result must be provided)

HEPATITIS B IMMUNIZATION OR LAB EVIDENCE OF IMMUNITY Three doses of Hepatitis B
immunization or serologic proof of immunity. Verification of serological proof of immunity
recommended, but must be 1 – 2 months after dose # 3.

Hepatitis B dose #1
(month day year)

Hepatitis B immunity
(month day year)

Hepatitis B dose #2
(month day year)

Hepatitis B dose #3
(month day year)

VARICELLA IMMUNIZATION (TWO DOSES) OR LAB EVIDENCE OF IMMUNITY

Varicella dose #1
(month day year)

Varicella dose #2
(month day year) (at least one month after dose # 1)

Varicella immunity
(month day year) (lab result must be provided)

TETANUS/ DIPHTHERIA/ PERTUSSIS IMMUNIZATION (Tdap within last 10 years, can be given regardless
of interval since last Td )

☐ Tdap
(month day year)

MENINGOCOCCAL MENINGITIS IMMUNIZATION (recommended) OR WAIVER

☐ Menactra/Menveo
(month day year)

☐ Decline immunization I have read the information provided and decline the Meningococcal Meningitis vaccine.

☐ Menomune
(month day year)

☐ (Recommended for first year students living in residence halls, If given before age 16, booster suggested)

Signature of student or parent/legal guardian if under 18 years of age

Date

3.25.15

Complete and return this Immunization Form before the deadline to avoid a $50 fee, registration hold, and restriction from participation in clinical activities.
DEADLINES: Fall – August 22 Spring – Jan 15th Summer - May 15th
Immunization Form

Name __________________________________________ UM Student # _____________________________

Last, First M. I.

TUBERCULOSIS SCREENING

Two Step PPD Screening (for those obtaining first PPD)

PPD Step 1 □ Positive □ Negative ______ mm induration month date year

PPD Step 2 (1-2 weeks after step 1, if step 1 negative) □ Positive □ Negative ______ mm induration month date year

Annual PPD (for those with negative PPD in the past)

PPD □ Positive □ Negative ______ mm induration month date year

Chest X-ray (required for positive PPD)

Chest X-ray □ Normal □ Abnormal ______ month date year

(copy of chest x-ray report must be attached to this form)

If PPD was positive and chest x-ray was negative: Was treatment of latent TB offered? □ Yes □ No

Was treatment of latent TB accepted? □ Yes □ No

Details of treatment including drug, dose, frequency and duration:
___________________________________________________________________________________

_________________________ _________________________
Name & title of physician or health care provider Signature Date

Symptom Review:

Do you have any of the following?

Cough (duration of 3 wks or more) yes ____ no ____
Chest Pain yes ____ no ____
Hemoptysis (coughing up blood) yes ____ no ____
Fever yes ____ no ____
Chills yes ____ no ____

Night Sweats yes ____ no ____
Appetite loss yes ____ no ____
Weight loss yes ____ no ____
Fatigue yes ____ no ____

_________________________ _________________________
Signature of Student Date

I attest that all dates and immunizations listed on this form are correct and accurate.

_________________________ _________________________
Name & title of physician or health care provider Signature Date

Address

__________________________________________
City State Zip Telephone

ENTER INFORMATION at mystudenthealth.miami.edu. Scan & save form on your computer or take a picture with your mobile device, and upload it at mystudenthealth.miami.edu. Alternatively, enter information and scan and email, fax or mail to: studenthealth@miami.edu, Fax (305) 284-4098, 5513 Merrick Drive, Coral Gables, FL 33146

Immunization information is provided to the State of Florida FLORIDA SHOTS immunization registry. Students can opt-out of the immunization registry by contacting us at studenthealth@miami.edu. This is an opt-out of sharing immunization information with the State of Florida registry and NOT an opt out of the immunization requirement.

VERIFICATION OF RECEIPT AND PROCESSING CAN BE OBTAINED at mystudenthealth.miami.edu