University of Miami Miller School of Medicine
Medical Student Immunization Record

Complete and return before JUNE 15th to avoid a registration hold and restriction from attending class.

I. TO BE COMPLETED BY STUDENT (please print)

Name _____ Entering UMMSM: 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 2) Serologic proof of immunity to measles, mumps and rubella

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

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

Measles immunity _____ _____ _____ ☐ copy attached
month day year

Rubella immunity _____ _____ _____ ☐ copy attached
month day year

Mumps immunity _____ _____ _____ ☐ copy attached
month day year

HEPATITIS B VACCINATION AND LAB EVIDENCE OF IMMUNITY:

3 doses of vaccine followed by a **quantitative** Hepatitis B Surface Antibody (titer) drawn at least 4 weeks after 3rd dose. If Hepatitis B Surface Antibody (titer) is negative (<10 IU/ml), please obtain a booster dose and repeat a titer 1-2 months later. Please submit the Medical Student Immunization Addendum **form** to document booster/additional doses.
Of note, needing a second series will NOT delay the start of medical school but must be completed as advised by the health center.

Hepatitis B dose #1 _____ _____ _____ QUANTITATIVE Hep B Surface Antibody ☐ positive ☐ negative
month day year

dose #2 _____ _____ _____ _____ _____ _____ ☐ copy attached
month day year month day year

dose #3 _____ _____ _____
month day year

VARICELLA IMMUNIZATION (TWO DOSES), OR LAB EVIDENCE OF IMMUNITY

Varicella dose #1 _____ _____ _____
month day year

Varicella dose #2 _____ _____ (at least one month apart)
month day year

Varicella immunity _____ _____ _____ ☐ copy attached
month day year

TETANUS/ DIPHTHERIA/ PERTUSSIS IMMUNIZATION (one dose on or after 11th birthday)

☐ Tdap _____ _____ _____
month day year

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Name _____ UM Student # _____
Last, First M. I.

TUBERCULOSIS (TB) SCREENING (Read Directions Carefully)

Please complete ONE section below: A or B AND all students must complete the annual symptom review below.

Section A: If you do not have a history of TB disease or LTBI (Latent Tuberculosis Infection), the results of a TB IGRA (Interferon Gamma Release Assay) blood test done in the last year are required, regardless of your prior BCG status.

Section B: If you have a history of a positive TST (PPD)>10mm or a positive IGRA, please supply information regarding further medical evaluation and treatment below.

Section A:

☐ **Negative IGRA blood test** Date _____ _____ _____ ☐ Copy attached
month date year

Section B: If a TB test (TB skin test or TB IGRA blood test) has been POSITIVE anytime, document below.

☐ **Positive Tuberculin Skin Test (TST)** Date _____ _____
month date year

☐ **Positive IGRA blood test** Date _____ _____ ☐ Copy attached
month date year

Symptom Review: Must be completed by all students upon enrollment and then annually.

Do you have any of the following?

Cough (duration of 3 wks or more)	yes _____ no _____	Night Sweats	yes _____ no _____
Chest Pain	yes _____ no _____	Appetite loss	yes _____ no _____
Hemoptysis (coughing up blood)	yes _____ no _____	Weight loss	yes _____ no _____
Fever	yes _____ no _____	Fatigue	yes _____ no _____
Chills	yes _____ no _____		

_____ _____
Signature of Student Date

Chest X-Ray Required **ONLY** for those with history of positive TB test (Tuberculin Skin Test or IGRA blood test)

Chest X-ray ☐ Normal ☐ Abnormal _____ _____ _____
month date year

(A copy of the chest X-ray report must be attached to this form)

If TB test 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

Recommended- COVID-19 Vaccine:

[]Pfizer []Moderna []Johnson and Johnson []AstraZeneca

[]Other: _____

[] Dose 1 ___ ___ ___ [] Dose 2 ___ ___ ___ [] Dose 3 ___ ___ ___

month date year month date year month date year

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

_____ _____ _____

Name & title of health care provider Signature Date

_____

Office Address

_____

City State Zip Telephone LICENSE # Licensed Professional Signature

Please upload the completed form along with any required documents to MyUHealthChart.com. If you have any questions, please email studenthealth@miami.edu

Sources: 1. Hepatitis B In: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. Washington D.C. Public Health Foundation, 2015 2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR, Vol 60(7):1-45 3. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62(RR10):1-19 4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67(1):1-31