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

dose #2 __________ 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 __________ 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 Meninogococcal 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 __________
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Immunization Form

<table>
<thead>
<tr>
<th>Name</th>
<th>UM Student #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last, First M. I.</td>
<td></td>
</tr>
</tbody>
</table>

**TUBERCULOSIS SCREENING**

**Two Step PPD Screening (for those obtaining first PPD)**

<table>
<thead>
<tr>
<th>PPD Step 1</th>
<th>Positive</th>
<th>Negative</th>
<th>mm induration</th>
<th>month</th>
<th>date</th>
<th>year</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD Step 2 (1-2 weeks after step 1, if step 1 negative)</td>
<td>Positive</td>
<td>Negative</td>
<td>mm induration</td>
<td>month</td>
<td>date</td>
<td>year</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PPD</th>
<th>Positive</th>
<th>Negative</th>
<th>mm induration</th>
<th>month</th>
<th>date</th>
<th>year</th>
</tr>
</thead>
</table>

**Chest X-ray (required for positive PPD)**

<table>
<thead>
<tr>
<th>Chest X-ray</th>
<th>Normal</th>
<th>Abnormal</th>
<th>mm induration</th>
<th>month</th>
<th>date</th>
<th>year</th>
</tr>
</thead>
</table>

(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

________________________
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

**UPLOAD INFORMATION** at mystudenthealth.miami.edu Alternatively, enter information and scan and email, fax or mail to: studenthealth@miami.edu, Fax (305) 284-4098, 5555 Ponce De Leon Blvd, 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