University of Miami School of Nursing
Immunization Form

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

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 _____ _____ _____(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 _____ _____ _____ (lab result must be provided)
month day year

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

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

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

Hepatitis B immunity (lab result must be provided) ☐ positive ☐ negative

_____ _____ _____
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 after dose # 1)
month day year

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

TETANUS/ DIPTHERIA/ 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

☐ Menomune _____ _____ _____
month day year

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

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

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

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	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

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.**eduAlternatively, 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