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

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Measles Immunity</th>
<th>Rubella Immunity</th>
<th>Mumps Immunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>month</td>
<td>day</td>
<td>year</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(after age 12 months, and in 1968 or later)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>month</td>
<td>day</td>
<td>year</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(at least 28 days after dose #1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hepatitis B Immunization or Lab Evidence of Immunity Three doses of Hepatitis B

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
<th>Hepatitis B Immunity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>month</td>
<td>day</td>
<td>year</td>
<td>positive □ negative □</td>
</tr>
<tr>
<td></td>
<td>month</td>
<td>day</td>
<td>year</td>
<td>(lab result must be provided)</td>
</tr>
<tr>
<td></td>
<td>month</td>
<td>day</td>
<td>year</td>
<td></td>
</tr>
</tbody>
</table>

Varicella Immunization (Two Doses) or Lab Evidence of Immunity

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Varicella Immunity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>month</td>
<td>day</td>
<td>year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(at least one month after dose #1)</td>
</tr>
<tr>
<td></td>
<td>month</td>
<td>day</td>
<td>year</td>
</tr>
</tbody>
</table>

Tetanus/ Diphtheria/ Pertussis Immunization (Tdap within last 10 years, can be given regardless of interval since last Td)

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dose 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap</td>
<td>month</td>
</tr>
</tbody>
</table>
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  ________ mm induration  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

On the basis of my review of the information furnished by the student and his/ her family, my own records including a recent physical examination and my ______ years of acquaintance with the student, it is my personal and professional judgment that the student is in good health and has no physical, emotional or social defects or problems and should be able to attend nursing or the Department of physical therapy school.

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

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

Immunization information is shared with the FLORIDA SHOTS registry. Contact studenthealth@miami.edu for registry opt-out information