University of Miami Immunization Record

Complete and return this form before the deadline.

DEADLINES: Fall – July 25 Spring - December 15
Summer - April 15

I. TO BE COMPLETED BY STUDENT (please print)

Name _____ UM Student# _____ Date of Birth ____ ____ _____
Last First M. I. mo day year

II. TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

REQUIRED: DOCUMENTATION OF MEASLES, MUMPS AND RUBELLA IMMUNIZATION, OR LAB EVIDENCE OF IMMUNITY. All students born after 1956 must have received either:
1) Two doses of MMR or serologic proof of immunity to measles, mumps and rubella and 2) Tdap
3) Dose of Meningococcal Meningitis (ACYW) in the last 5 years is required of all undergraduate students.

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

dose #2 _____ _____ _____ (at least 30 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

Tdap _____ _____ _____ (one dose on or after 11th birthday)
month day year

Meningococcal Meningitis ☐☐ ☐ Menactra/ Menveo/Menquadfi ____ ____ ____
mo day yr

Students who wish to decline Meningococcal Meningitis Immunization **must fill out a separate declination form available on the Student Health Website.**

REQUIRED IMMUNIZATIONS OR SIGNATURE DECLINING: Hepatitis B (3 shots)

Hepatitis B Dose #1 ____ ____ ____ Dose #2 ____ ____ ____ Dose #3 ____ ____ ____
mo day yr mo day yr mo day yr

☐ I have read the information provided and decline the **Hepatitis B** vaccine

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

RECOMMENDED: Varicella (Chicken Pox)

Varicella History of disease? ☐ yes ☐ no Immunity ____ ____ ____
mo day yr

Dose #1 ____ ____ ____ Dose #2 ____ ____ ____
mo day yr mo day yr

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

_____
Name & title of health care provider Signature Date

_____
Address

_____
City State Zip Telephone

Upload form to: MyUHealthChart.com Alternatively, email form to: studenthealth@miami.edu,

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

REQUIRED: ALL INTERNATIONAL STUDENTS must answer the questions on page two of this form to determine the requirement for additional Tuberculosis (Tb) screening. Tb testing must be completed within six months prior to arrival on campus, or by one month after arrival on campus.

III: TUBERCULOSIS SCREENING FOR INTERNATIONAL STUDENTS:

1. Have you been in close contact with anyone sick with tuberculosis? Yes ☐ No ☐

   If yes, tuberculosis testing is required, regardless of country of origin.

2. Were you born in a country other than those listed below? Yes ☐ No ☐

   If yes, tuberculosis testing is required.

   Please list country of birth: _____

3. Have you traveled to any country other than those listed below for greater than one month ? Yes ☐ No ☐

   If yes, tuberculosis testing is required.

   Please list all countries that you have lived in or traveled to for greater than one month:

   _____

If you answered yes to any of the above questions, TB testing is necessary and must be performed within six months prior to arrival on campus, or by one month after arrival on campus.

If you answered no to all of the above questions, no additional tuberculosis testing is required.

_____ _____
Signature of student: Date

Low Risk Countries

American Samoa	Curacao	Jamaica	Saint Vincent and the Grenadines
Andorra	Cyprus	Jordan	San Marino
Antigua and Barbuda	Czech Republic	Luxembourg	Slovakia
Aruba	Denmark	Monaco	Slovenia
Australia	Finland	Montserrat	Spain
Austria	France	Netherlands	Sweden
Barbados	Germany	New Caledonia	Switzerland
Belgium	Greece	New Zealand	United Arab Emirates
Bermuda	Grenada	Niue	United Kingdom
British Virgin Islands	Hungary	Norway	United States of America
Canada	Iceland	Oman	US Virgin Islands
Cayman Islands	Ireland	Puerto Rico	West Bank and Gaza Strip
Croatia	Israel	Saint Kitts and Nevis	
Cuba	Italy	Saint Lucia	

PPD or IGRA Testing (required if you answered yes to any of the above questions)

PPD ☐ Negative ☐ Positive _____ mm induration _____month _____ year

IGRA Testing ☐ Negative ☐ Positive _____month _____ year (Lab result must be provided)

If positive, a chest X-ray is required (copy of chest x-ray report must be attached to this form):

Chest X-ray ☐ Normal ☐ Abnormal _____date

If PPD was positive and chest X-ray was negative, was treatment of latent Tb accepted? ☐ Yes ☐ No

Details of treatment including drug, dose, frequency and duration._____

_____ _____
Signature of Health Care Provider: Date