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 ________________________________ M. I.  
Last, First  
UM Student # ____________________________  
Entering UMMSM: Yr ____  
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

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose 1</th>
<th>Dose 2</th>
</tr>
</thead>
</table>
| MMR     | month  | day    | year  | (after age 12 months, and in 1968 or later)  
|         | month  | day    | year  | (at least 28 days after dose #1)  
| Measles immunity | month | day | year | □ copy attached  
| Rubella immunity | month | day | year | □ copy attached  
| Mumps immunity | month | day | year | □ copy attached  

**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.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
<th>Quantitative Hep B Surface Antibody</th>
<th>□ positive</th>
<th>□ negative</th>
</tr>
</thead>
</table>
| Hepatitis B | month | day | year | month | day | year | □ copy attached  

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

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose 1</th>
<th>Dose 2</th>
</tr>
</thead>
</table>
| Varicella | month | day | year | (at least one month apart)  
| Varicella immunity | month | day | year | □ copy attached  

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

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap</td>
<td>month</td>
</tr>
<tr>
<td>Tdap</td>
<td>month</td>
</tr>
</tbody>
</table>

□ Tdap  
□ Tdpa
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
  month date year
  □ Copy attached

Section B:

- Positive Tuberculin Skin Test (TST)
  Date
  month date year
- Positive IGRA blood test
  Date
  month date year
  □ Copy attached

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 ______
   month date year

[ ] Dose 2 ______
   month date year

[ ] Dose 3 ______
   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: