

**University of Miami Miller School of Medicine
Medical Student Immunization Record**

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 _____
Last, First M. I.

Entering UMMSM: Yr _____

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 2) 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 _____ copy attached
month day year

Rubella immunity _____ copy attached
month day year

Mumps immunity _____ copy attached
month day year

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.

Hepatitis B dose #1 _____ QUANTITATIVE Hep B Surface Antibody positive negative
month day year

dose #2 _____ copy attached
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 _____ (at least one month apart)
month day year

Varicella immunity _____ copy attached
month day year

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

Tdap _____
month day year

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

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 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 _____ Copy attached
month date year

Section B: If a TB test (TB skin test or TB IGRA blood test) has been POSITIVE anytime, document below.

Positive Tuberculin Skin Test (TST) Date _____
month date year

Positive IGRA blood test Date _____ Copy attached
month date year

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

COVID-19 VACCINE: All medical students should be fully vaccinated against COVID-19 barring any approved medical and religious exemptions. Please follow CDC guidance for when you are considered up to date on COVID vaccination.

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: 1. Hepatitis B In: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. Washington D.C. Public Health Foundation, 2015 2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR, Vol 60(7):1-45 3. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62(RR10):1-19 4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67(1):1-31