University of Miami School of Nursing
Immunization Form

I. TO BE COMPLETED BY STUDENT (please print)

Name _____________________ Last, First M. I. Entering UM: Fall ___ Spring ___ Summer ___ 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 Serologic proof of immunity to measles, mumps and rubella

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

dose #2 month day year (at least 28 days after dose #1)

Measles immunity month day year (lab result must be provided)

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

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

HEPATITIS B IMMUNIZATION OR LAB EVIDENCE OF IMMUNITY
Three doses of Hepatitis B immunization or serologic proof of immunity.

Hepatitis B dose #1 month day year Hepatitis B immunity ___ positive ___ negative

Hepatitis B immunity month day year (lab result must be provided)

dose #2 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 month day year (at least one month after dose #1)

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

TETANUS/ DIPHTHERIA/ PERTUSSIS IMMUNIZATION
(one dose of Tdap or Td within the last 10 years)

□ Tdap month day year □ Td month day year

TETANUS/ DIPHTHERIA/ PERTUSSIS IMMUNIZATION OR DECLINATION

Menactra/Menveo/Menquadfi month day year

□ Decline immunization: I have read the information provided and decline the Meningooccal Meningitis vaccine.

Signature of Student ________________________________ Date ____________________

Complete and return this Immunization Form before the deadline.

DEADLINES: Fall – July 25 Spring – December 15 Summer – April 15th
Name ___________________________ UM Student # _____________________________

Last, First M. I.

**TUBERCULOSIS SCREENING:** Students must have an IGRA blood test within the last year prior to enrollment, unless they have a history of a positive PPD or IGRA, in which case a copy of the positive chest and chest x-ray result/report must be submitted.

**IGRA (Quantiferon or T-spot)**
- Positive
- Negative

(Lab result must be provided)

**PPD**
- Positive
- Negative

(mm induration)

**Chest X-ray (required for positive TB test)**
- Normal
- Abnormal

(copied of chest x-ray report must be attached to this form)

If PPD/IGRA 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:

___________________________________________________________________________________

**Symptom Review:** Must be completed upon enrollment and then annually.

- Cough (duration of 3 wks or more)
- Chest Pain
- Hemoptysis (coughing up blood)
- Fever
- Chills

- Night Sweats
- Appetite loss
- Weight loss
- Fatigue

___________________________________________________________________________________

Signature of Student Date

**Recommended- COVID-19 vaccine:**

- [ ] Pfizer
- [ ] Moderna
- [ ] Johnson and Johnson
- [ ] AstraZeneca

[ ] Dose 1 __________ __________ __________

[ ] Dose 2 __________ __________ __________

[ ] Dose 3 __________ __________ __________

I attest that all dates and immunizations listed on this form are correct and accurate.

Name & title of health care provider Signature Date

Address

City State Zip Telephone

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