University of Miami School of Nursing
Immunization Form

Complete and return this Immunization Form before the deadline to avoid a $50 fee, registration hold, and restriction from participation in clinical activities.

DEADLINES: Fall – July 15 Spring – December 15
Summer – April 15th

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

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 _____ _____ _____ (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

HEPATITIS B IMMUNIZATION OR LAB EVIDENCE OF IMMUNITY Three doses of Hepatitis B immunization or serologic proof of immunity. Verification of serological proof of immunity recommended, but must be 1 – 2 months after dose # 3.

Hepatitis B dose #1 _____ _____ _____
month day year

dose #2 _____ _____ _____
month day year

dose #3 _____ _____ _____
month day year

Hepatitis B immunity (lab result must be provided) ☐ positive ☐ negative

_____ _____ _____
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 after dose # 1)
month day year

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

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

☐ Tdap _____ _____ _____
month day year

MENINGOCOCCAL MENINGITIS IMMUNIZATION (recommended) OR WAIVER

☐ Menactra/Menveo _____ _____ _____
month day year

☐ Menomune _____ _____ _____
month day year

☐ (Recommended for first year students living in residence halls, If given before age 16, booster suggested)

☐ Decline immunization I have read the information provided and decline the **Meningococcal Meningitis** vaccine.

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

5.17.18

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 _____ _____ _____
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 _____	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

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

_____ _____ _____
Name & title of physician or health care provider Signature Date

_____
Address

_____
City State Zip Telephone

ENTER INFORMATION at **mystudenthealth.miami.edu** Scan & save form on your computer or take a picture with your mobile device, and upload it 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, Coral Gables, FL 33146

Immunization information is provided to the State of Florida FLORIDA SHOTS immunization registry. Students can opt-out of the immunization registry by contacting us at studenthealth@miami.edu . This is an opt-out of sharing immunization information with the State of Florida registry and NOT an opt out of the immunization requirement.

VERIFICATION OF RECEIPT AND PROCESSING CAN BE OBTAINED at mystudenthealth.miami.edu 5.17.18