University of Miami School of Nursing
Immunization Form

Complete and return this Immunization Form before the deadline.

DEADLINES: Fall – July 25 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.

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 of Tdap or Td within the last 10 years)

☐ Tdap _____ _____ _____
month day year

☐ Td _____ _____ _____
month day year

MENINGOCOCCAL MENINGITIS IMMUNIZATION OR DECLINATION

☐ Menactra/Menveo/Menquadfi _____ _____ _____ _____ _____ _____ _____ ____
month day year

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

_____ _____
Signature of Student Date

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) month day year

PPD ☐ Positive ☐ Negative _____ mm induration _____ _____ _____ _
month day year

Chest X-ray (required for positive TB test)

Chest X-ray ☐ Normal ☐ Abnormal _____ _____ _____
month day year
(copy 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.

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

Recommended- COVID-19 vaccine:

[]Pfizer []Moderna []Johnson and Johnson []AstraZeneca
[]Other: _____

[] Dose 1 ___ ___ ___ [] Dose 2 ___ ___ ___ [] Dose 3 ___ ___ ___
month day year month day year month day year

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,