University of Miami School of Nursing
Immunization Form

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 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. Verification of serological proof of immunity
recommended, but must be 1 – 2 months after dose # 3.
Hepatitis B dose #1 month day year
Hepatitis B immunity (lab result must be provided) month day year
Hepatitis B dose #2 month day year
Hepatitis B 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 on or after 11th birthday)
□ Tdap month day year

MENINGOCOCCAL MENINGITIS IMMUNIZATION (recommended) OR WAIVER
□ Menactra/Menveo month day year
□ Menomune month day year
□ Decline immunization. I have read the information provided and decline the Meningococcal Menigitis vaccine.

□ (Recommended for first year students living in residence halls, If given before age 16, booster suggested) Signature of student or parent/legal guardian if under 18 years of age
Date

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 15

5.17.18
Immunization Form

Name ___________________________ UM Student # ___________________________

Last, First M. I.

TUBERCULOSIS SCREENING

Two Step PPD Screening (for those obtaining first PPD)

<table>
<thead>
<tr>
<th>PPD Step 1</th>
<th>Positive □ Negative □ mm induration □ mm induration □ mm induration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>month date year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PPD Step 2 (1-2 weeks after step 1, if step 1 negative)</th>
<th>Positive □ Negative □ mm induration □ mm induration □ mm induration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>month date year</td>
</tr>
</tbody>
</table>

Annual PPD (for those with negative PPD in the past)

<table>
<thead>
<tr>
<th>PPD</th>
<th>Positive □ Negative □ mm induration □ mm induration □ mm induration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>month date year</td>
</tr>
</tbody>
</table>

Chest X-ray (required for positive PPD)

<table>
<thead>
<tr>
<th>Chest X-ray</th>
<th>Normal □ Abnormal □ mm induration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>month date year</td>
</tr>
</tbody>
</table>

(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 ___
- Chest Pain yes ___ no ___
- Hemoptysis (coughing up blood) yes ___ no ___
- Fever yes ___ no ___
- Chills yes ___ no ___
- Night Sweats yes ___ no ___
- Appetite loss yes ___ no ___
- Weight loss yes ___ no ___
- Fatigue 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