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 _______ _______ _______ (after age 12 months, and in 1968 or later)
dose #2 _______ _______ _______ (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 _______ _______ _______
Hepatitis B immunity _______ _______ _______
(month day year) (lab result must be provided)

Hepatitis B dose #2 _______ _______ _______
Hepatitis B immunity _______ _______ _______
(month day year) (lab result must be provided)

Hepatitis B dose #3 _______ _______ _______
Hepatitis B immunity _______ _______ _______
(month day year) (lab result must be provided)

VARICELLA IMMUNIZATION (TWO DOSES) OR LAB EVIDENCE OF IMMUNITY

Varicella dose #1 _______ _______ _______
Varicella dose #2 _______ _______ _______
Varicella immunity _______ _______ _______
(month day year) (at least one month after dose # 1)
(month day year) (lab result must be provided)

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

Tdap _______ _______ _______
Td _______ _______ _______
(month day year) (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

Complete and return this Immunization Form before the deadline.
DEADLINES: Fall – July 25  Spring – December 15
Summer – April 15th
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)

Chest X-ray  □ Normal  □ Abnormal
(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    __
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    __

COVID-19 VACCINE:

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

[] Dose 1  ___ ___ ___
month day year

[] Dose 2  ___ ___ ___
month day year

[] Dose 3  ___ ___ ___
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.