University of Miami School of Nursing
Immunization Form

I. TO BE COMPLETED BY STUDENT (please print)

Name ____________________________________________
Last, First M. I.
UM Student # ________________________________ Date of Birth ________ ________ ________

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

Hepatitis B immunity □ positive □ negative

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

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

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

□ Tdap _______ _______ ________
month day year

□ Td _______ _______ ________
month day year

MENINGOCOCCAL MENINGITIS IMMUNIZATION (recommended) OR WAIVER

□ Menactra/Menveo _______ _______ ________
month day year

□ Decline immunization I have read the information provided

□ Menomune _______ _______ ________
month day year

and decline the Meningococcal Meningitis 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.
DEADLINES: Fall – July 15 Spring – December 15 Summer – April 15th
Name ________________________________ UM Student # _____________________________

Last, First M. I.

TUBERCULOSIS SCREENING (Students must have IGRA blood test or PPD within the last year unless they have history of positive PPD in which case copy of chest x-ray result must be submitted)

IGRA (Quantiferon) □ Positive □ Negative  month date year

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 accepted? □ Yes □ No

Details of treatment including drug, dose, frequency and duration:
___________________________________________________________________________________

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 ______________

COVID-19 VACCINE: Please note this is NOT a requirement at this time but may be a requirement in the future. If you have received it, please include the type, dates and copy of record.

[] Pfizer (2 doses) [] Moderna (2 doses) [] Johnson and Johnson (1 dose) [] AstaZeneca (2 doses)
[] Other: ____________________________

[] Dose 1 ___ ___ ___  month date year  [] Dose 2 ___ ___ ___  month date year

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 and upload form at mystudenthealth.miami.edu. Alternatively, email form to: studenthealth@miami.edu.
Immunization information is shared with the FLORIDA SHOTS registry. Contact studenthealth@miami.edu for registry opt-out information.