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. 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) ☐ positive ☐ negative
______ _____ _____
month day year

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 ______ _____ _______
month day year (lab result must be provided)

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

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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 _____
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

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,