University of Miami Department of Physical Therapy
Immunization Form

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 15th 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

dose #2 _____ _____ _____
month day year

dose #3 _____ _____ _____
month day year

Hepatitis B immunity ☐ positive ☐ negative
(lab result must be provided)
_____ _____ _____
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 on or after 11th birthday)

☐ Tdap _____ _____ _____
month day year

Name _____ UM Student # _____
Last, First M. I.

TUBERCULOSIS SCREENING

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 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	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

On the basis of my review of the information furnished by the student and his/ her family, my own records including a recent physical examination and my_____years of acquaintance with the student, it is my personal and professional judgment that the student is in good health and has no physical, emotional or social defects or problems and should be able to attend nursing or the Department of physical therapy school.

_____ _____ _____
Name & title of physician or health care provider Signature Date

_____
Address

_____
City State Zip Telephone

UPLOAD INFORMATION 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 Blvd, Coral Gables, FL 33146

VERIFICATION OF RECEIPT AND PROCESSING CAN BE OBTAINED at mystudenthealth.miami.edu

Immunization information is shared with the FLORIDA SHOTS registry. Contact studenthealth@miami.edu for registry opt-out information