University of Miami Department of Physical Therapy
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 ____________ ____________ ____________

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 immunization of immunity to measles, mumps and rubella

MMR dose #1 _____ _____ _____ (after age 12 months, and in 1968 or later)
month day year

MMR 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 _____ _____ _____ (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 ____________ (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 on or after 11th birthday)

☐ Tdap _____ _____ _____
month day year
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 xray result must be submitted)

IGRA (Quantiferon)  □ Positive □ Negative  ___________  ___________  ___________

Two Step PPD Screening (for those obtaining first PPD)

PPD Step 1  □ Positive □ Negative  ________ mm induration  ___________  ___________  ___________

PPD Step 2 (1-2 weeks after step 1, if step 1 negative)  □ Positive □ Negative  ________ mm induration  ___________  ___________  ___________

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

PPD  □ Positive □ Negative  ________ mm induration  ___________  ___________  ___________

Chest X-ray  (required for positive PPD)

Chest X-ray  □ Normal □ Abnormal  ________  ________  ________

(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.