

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 – August 22 Spring – Jan 15th
Summer - May 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 _____ Hepatitis B immunity positive negative
month day year (lab 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 (Tdap within last 10 years, can be given regardless of interval since last Td)

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