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 ____________ 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 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.

Hepatitis B dose #1 ________ ________ ________ Hepatitis B immunity ______ positive ______ negative

month____ day____ year____ (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 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 chest x-ray result must be submitted.

**IGRA (Quantiferon or T-spot)**

- Positive □ 　Negative □ 　　 month date year

**PPD**

- Positive □ 　Negative □ 　mm induration 　 month date year

**Chest X-ray** (required for positive PPD or IGRA)

- Normal □ 　Abnormal □ 　month date 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 □ 　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 ______________

**Recommended- COVID-19 Vaccine:**

- [ ] Pfizer  [ ] Moderna  [ ] Johnson and Johnson  [ ] AstraZeneca  [ ] Other: _____________

- [ ] Dose 1 _______ 　month date year
- [ ] Dose 2 _______ 　month date year
- [ ] Dose 3 _______ 　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 __________

Upload form at MyUHealthChart.com Alternatively, email form to: studenthealth@miami.edu.