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
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 ___________ _______ (lab result must be provided)
month day year
dose #3 ___________ _______ (lab result must be provided)
month day year

VARICELLA IMMUNIZATION (TWO DOSES) OR LAB EVIDENCE OF IMMUNITY

Varicella dose #1 ___________ _______ (at least one month after 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
Immunization Form

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

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

(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 Nightsweats 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