University of Miami Department of Physical Therapy
Immunization Form

Complete and return this Immunization Form before the deadline

DEADLINES: Fall – July 25 Spring – December 15
Summer - April 15

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: 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 _____ year

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

Chest X-ray ☐ 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

COVID-19 VACCINE:

[]Pfizer []Moderna []Johnson and Johnson []AstraZeneca
[]Other: _____

[] Dose 1 ___ ___ ___ [] Dose 2 ___ ___ ___ [] Dose 3 ___ ___ ___
month date year month date year 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,