University of Miami Immunization Record

Complete and return this form before the deadline.

DEADLINES: Fall – July 15nd Spring - December 15th
Summer - April 15th

I. TO BE COMPLETED BY STUDENT (please print)

Name _____ UM Student# _____ Date of Birth ____ ____ _____
Last First M. I. mo day year

II. TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

REQUIRED: DOCUMENTATION OF MEASLES, MUMPS AND RUBELLA IMMUNIZATION, OR LAB EVIDENCE OF IMMUNITY. All students born after 1956 must have received either:
1) Two doses of MMR or serologic proof of immunity to measles, mumps and rubella and 2) Tdap
3) Meningococcal Meningitis (ACYW) is required of all undergraduate students

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

dose #2 _____ _____ _____ (at least 30 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

Tdap _____ _____ _____ (one dose on or after 11th birthday)
month day year

Meningococcal Meningitis ☐☐ Menactra/ Menveo or ☐☐ Menomune _____ _____ _____
mo day yr

Graduate students ONLY who wish to decline meningitis vaccine can sign declination below:
☐ I have read the information provided and decline the **Meningitis** vaccine

_____ _____
Signature of student or parent/legal guardian if under 18 years of age date

REQUIRED IMMUNIZATIONS OR SIGNATURE DECLINING: Hepatitis B (3 shots)

Hepatitis B Dose #1 ____ ____ ____ Dose #2 ____ ____ ____ Dose #3 ____ ____ ____
mo day yr mo day yr mo day yr

☐ I have read the information provided and decline the **Hepatitis B** vaccine

_____ _____
Signature of student or parent/legal guardian if under 18 years of age date

RECOMMENDED: Varicella (Chicken Pox)

Varicella History of disease? ☐ yes ☐ no Immunity ____ ____ ___
mo day yr

Dose #1 ____ ____ ____ Dose #2 ____ ____ ____
mo day yr mo day yr

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)
[]Other: _____

[] Dose 1 ___ ___ ___ [] Dose 2 ___ ___ ___ [] Booster ___ ___ ___
month date year month date year month date year

_____
Name & title of physician or health care provider Signature Date

_____
Address

_____
City State Zip Telephone

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

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Name _____ UM Student # _____
Last First M. I.

REQUIRED: ALL INTERNATIONAL STUDENTS must answer the questions on page two of this form to determine the requirement for additional Tuberculosis (Tb) screening. Tb testing must be completed within six months prior to arrival on campus, or by one month after arrival on campus.

III: TUBERCULOSIS SCREENING FOR INTERNATIONAL STUDENTS:

1. Have you been in close contact with anyone sick with tuberculosis? Yes ☐ No ☐

   If yes, tuberculosis testing is required, regardless of country of origin.

2. Were you born in a country other than those listed below? Yes ☐ No ☐

   If yes, tuberculosis testing is required.

   Please list country of birth: _____

3. Have you traveled to any country other than those listed below for greater than one month ? Yes ☐ No ☐

   If yes, tuberculosis testing is required.

   Please list all countries that you have lived in or traveled to for greater than one month:

   _____

If you answered yes to any of the above questions, PPD testing is necessary and must be performed within six months prior to arrival on campus, or by one month after arrival on campus.

If you answered no to all of the above questions, no additional tuberculosis testing is required.

_____ _____
Signature of student: Date

Low Risk Countries

Albania	Czech Republic	Italy	Saint Kitts and Nevis
Andorra	Denmark	Jamaica	Saint Lucia
Antigua and Barbuda	Dominica	Jordan	Samoa
Australia	Egypt	Lebanon	Saudi Arabia
Austria	Fiji	Luxembourg	Slovakia
Bahamas	Finland	Malta	Slovenia
Barbados	France	Mexico	Spain
Belgium	Germany	Monaco	Sweden
Bermuda	Greece	Montserrat	Switzerland
British Virgin Islands	Greenland	Nauru	United Arab Emirates
Canada	Grenada	Netherlands	United Kingdom
Cayman Islands	Hungary	Netherlands Antilles	United States of America
Chile	Iceland	New Zealand	US Virgin Islands
Costa Rica	Iran	Norway	West Bank and Gaza Strip
Cuba	Ireland	Oman	
Cyprus	Israel	Puerto Rico	

PPD Testing (required if you answered yes to any of the above questions)

PPD (Mantoux 5 TU only) ☐ Negative ☐ Positive _____ mm induration _____month _____ year

If positive, a chest X-ray is required (copy of chest x-ray report must be attached to this form):

Chest X-ray ☐ Normal ☐ Abnormal _____date

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._____

_____ _____
Signature of Health Care Provider: Date