

University of Miami School of Nursing Immunization Record

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 – July 15th Spring – Dec 15th
Summer - April 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 2) 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

dose #2 _____ month day year

dose #3 _____
month day year

VARICELLA IMMUNIZATION (TWO DOSES), ILLNESS CONFIRMED BY MEDICAL PROVIDER 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

Varicella or Herpes Zoster confirmed by medical professional (documentation must be attached)

TETANUS/ DIPHTHERIA/ PERTUSSIS IMMUNIZATION (within 10 years)

Tdap (unless Td within last two yrs) _____ Td _____
month day year month day year

MENINGOCOCCAL MENINGITIS IMMUNIZATION (recommended) OR WAIVER

Menactra _____
month day year

Decline immunization I have read the information provided and decline the **Meningococcal Meningitis** vaccine.

Menomune _____
month day year

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

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

TUBERCULOSIS SCREENING

Initial Screening 2 step PPD (unless PPD done elsewhere within the past 12 months)

PPD Step 1 (Mantoux 5TU only) Positive Negative _____ mm induration _____ month _____ date _____ year

PPD Step 2 (Mantoux 5TU only) Positive Negative _____ mm induration _____ month _____ date _____ year
(1-3 weeks after first test)

Annual PPD Screening

PPD (Mantoux 5TU only) 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: (required for positive PPD)

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 school.

Name & title of physician or health care provider

Signature

Date

Address

City

State

Zip

Telephone