

University of Miami School of Nursing & Department of Physical Therapy 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 – August 22 Spring – Jan 15th
Summer - May 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 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 (lab result must be provided) _____
dose #2 _____ month day year
month day year
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 (Tdap within last 10 years, can be given regardless of interval since last Td)

Tdap _____
month day year

MENINGOCOCCAL MENINGITIS IMMUNIZATION (recommended) OR WAIVER

Menactra _____ Decline immunization I have read the information provided
month day year and decline the Meningococcal Meningitis vaccine.
 Menomune _____
month day year
 Menveo _____
month day year

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

date

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

TUBERCULOSIS SCREENING

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:

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 or the Department of physical therapy school.

Name & title of physician or health care provider Signature Date

Address

City State Zip Telephone

ENTER INFORMATION at mystudenthealth.miami.edu and return completed form to: **Student Health Service**
5513 Merrick Drive, Coral Gables, FL 33146 Fax (305) 284-4098 studenthealth@miami.edu

Immunization information is provided to the State of Florida FLORIDA SHOTS immunization registry. Students can opt out of this immunization registry by completing an opt-out form, available at www.miami.edu/student-health

VERIFICATION OF RECEIPT AND PROCESSING CAN BE OBTAINED at mystudenthealth.miami.edu 02.20.12