

# University of Miami Immunization Record

Complete and return this form before the deadline to avoid a \$50 fee and /or registration hold.  
**DEADLINES:** Fall - August 22<sup>nd</sup> Spring - January 15<sup>th</sup>  
Summer - April 15<sup>th</sup>

## 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

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 \_\_\_\_\_ (within last 10 years, may be given regardless of interval since last Td)  
month day year

**REQUIRED IMMUNIZATIONS OR SIGNATURE DECLINING: Hepatitis B (3 shots), Meningococcal Meningitis**

**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

**Meningococcal Meningitis**  Menactra or  Menomune \_\_\_\_\_  
mo day yr

I have read the information provided and decline the **Meningococcal Meningitis** 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

**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.

\_\_\_\_\_  
Name & title of physician or health care provider Signature Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Telephone

**III. ENTER INFORMATION** at [mystudenthealth.miami.edu](http://mystudenthealth.miami.edu) **AND** return completed form to: **Student Health Service**  
5513 Merrick Drive, Coral Gables, FL 33146, fax to (305) 284-4098 or scan/ email to [studenthealth@miami.edu](mailto: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](http://www.miami.edu/student-health)

**VERIFICATION OF RECEIPT AND PROCESSING CAN BE OBTAINED** at [mystudenthealth.miami.edu](http://mystudenthealth.miami.edu)

**University of Miami Immunization Record - page 2 (required for International Students only)**

Name \_\_\_\_\_ UM Student # \_\_\_\_\_  
Last First M. I.

**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 offered?  Yes  No

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. \_\_\_\_\_

\_\_\_\_\_  
Name & title of physician or health care provider

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date