## **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>

## **I.** 7

Name_		BYSIC	JDENT	(please	print)					r - April 15		
1 turric_						_UM Student#			Date of Bi	rth		
	Last	F	First		M. I.					mo	day	y
ЭВЕ СО	MPLETE	D AND S	SIGNE	D BY HI	EALTH CA	ARE PROVIDI	ER					
REQUI EVIDE	NCE OF I	MMUN	ITY. A	ll stude	nts born af	, MUMPS AND ter 1956 must be immunity to r	have received	either:			3	
MMR	dose #1				(after age	12 months, and	l in 1968 or lat	er)				
		month	day	year								
	dose #2	month	day	year	(at least 30	days after dose	#1)					
Magalag			•	•	(lab magnit	must be marride	.4\					
Measies	simmunity	month	day	year	(lab result	must be provide	:u)					
Rubella	immunity				(lab result	must be provide	ed)					
		month	day	year								
Mumps	immunity	month	day	vear	(lab result	must be provide	ed)					
Tdon		шошш	uay	•	(within 1-	nt 10 mages	ho given mess	rdlagg of :	omiol oir -	o lost T-1	`	
Tdap					(within las	st 10 years, may	be given regai	raiess of in	ervai sinc	e iast 1 a	)	
		month	day	year								
REQU	IRED IMN	<b>IUNIZA</b>	TIONS	S <u>OR</u> SI	GNATURI	E DECLINING	: Hepatitis B	(3 shots), N	<b>Ieningoc</b>	occal Me	eningit	is
Hepatit	tis B	Dose #	1		Dose	e #2		Dose #3				
•			mo	day	yr	mo day	yr	1	no day	yr		
			□ Ih	ave read	l the inform	ation provided	and decline the	Hepatitis	B vaccine	:		
				_	_	arent/legal guardiar	-	of age	date			
				□ Mer	nactra/Men	veo or $\square$	Menomune					
Menin	gococcal N	Meningit	tis					mo day	yr	-		
	O	Ü			n residence	halls. If given b	efore age 16, b		gested)			
(recomi	nended for	1 <sup>st</sup> year s	students	living in		_		ooster sugg				
(recomi	nended for	1 <sup>st</sup> year s	students	living in		halls. If given b		ooster sugg				
(recomi	nended for	1 <sup>st</sup> year s	students ation pro	living in	nd decline tl	_	cal Meningitis	ooster sugg				
(recomi	nended for	1 <sup>st</sup> year s	students	living in	nd decline the	ne <b>Meningoco</b> c	cal Meningitis	ooster sugg	gested)	_		
(recomi	mended for ave read the	1 <sup>st</sup> year s e informa	students ation pro	living in ovided an Signature of (Chicke	of student or poen Pox)	ne <b>Meningococ</b> arent/legal guardiar	cal Meningitis	ooster sugg	gested)	_		
(recomi	mended for ave read the model of the model o	1 <sup>st</sup> year s e informa ED: Vs	students ation pro	living in ovided an Signature of (Chicke	of student or poen Pox)	ne <b>Meningococ</b> arent/legal guardiar Immunity	cal Meningitis	ooster sugg	gested)			
(recomi	mended for ave read the model of the model o	1 <sup>st</sup> year s e informa	students ation pro	living in ovided an Signature of (Chicko	of student or poen Pox)	ne <b>Meningococ</b> arent/legal guardiar	cal Meningitis	ooster sugg	gested)	_		
(recoming I has RECO	mended for ave read the object of the object	1 <sup>st</sup> year s e informa ED: Vs ry of dise se #1	aricella	living in ovided an Signature of (Chicko	of student or page Pox)  □ no	arent/legal guardiar  Immunity  Dose #2	cal Meningitis	ooster sugg	ested) date			4h.
(recomi	mended for ave read the DMMENDE la Histor Dos	1 <sup>st</sup> year s e informa ED: Vs ry of dise se #1 L INTEL itional Te	aricella  aricella  aricella  aricella  aricella	living in ovided an Signature of (Chicko	of student or page no	ne <b>Meningococ</b> arent/legal guardiar Immunity	cal Meningitis	ooster sugg s vaccine of age n page two	ested) date			

UPLOAD INFORMATION at mystudenthealth.miami.edu Alternatively, enter information and scan and email, fax or mail to: studenthealth@miami.edu, Fax (305) 284-4098, 5555 Ponce De Leon Blvd, Coral Gables, FL 33146

Zip

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

State

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

Name			nt #	_					
Last III: TUBERCULOSIS	First SCREENING FOR	M. I. INTERNATIONAL STUD	DENTS:						
1. Have you been in cl	ose contact with anyon	ne sick with tuberculosis?	Yes □ No □						
•	•	ed, regardless of country o	f origin						
•	_								
·	. Were you born in a country other than those listed below? Yes $\square$ No $\square$								
If yes, tuberculo	osis testing is required								
Please list countr	ry of birth:								
3. Have you traveled to than one month?	o any country other tha	an those listed below for great	ater Yes $\square$ No $\square$						
If yes, tubercu	losis testing is requir	ed.							
Please list all cou	untries that you have li	ved in or traveled to for grea	ater than one month:						
performed within six m	onths prior to arriva	otions, PPD testing is necessal on campus, or by one moreons, no additional tubercul	nth after arrival on campus.						
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	l if you answered ves	to any of the above question	ons)						
PPD (Mantoux 5 TU onl		□ Positivemm ii		,					
•	• ,	hest x-ray report must be att		•					
Chest X-ray	nal   Abnormal	date							
If PPD was positive and	chest X-ray was negat	rive, was treatment of latent	Tb offered? □ Yes □ No						
If PPD was positive and	chest X-ray was negat	tive, was treatment of latent	Tb accepted? ☐ Yes ☐ No						
tails of treatment including	ng drug, dose, frequen	cy and duration		_					
.ma	m boolth 11	C:	Diff						
me & title of physician of	meann care provider	Signature	Date						