## University of Miami Miller School of Medicine Medical Student Immunization Record

## Complete and return before JULY 1st to avoid a registration hold and restriction from attending class.

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Name					M. I.		Entering	UMN	ISM: Yr	·	_	
Last,		Fir	est		M. I.							
UM Student # _							Date of	Birth		day	vear	
									month	uay	year	
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MMR dose #1				(afte	er age 12 month	s, and in	n 1968 or la	iter)				
	month	day	y yea	r								
dose #2				(at le	ast 28 days afte	r dose #	<b>#1</b> )					
				(410 101	use 20 days are		/					
	month	day	y year									
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Duballa immunit		-	•		ony attached							
Rubella immunit	month	day			opy attached							
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TETANUS/ DIPHTHERIA/ PERTUSSIS IMMUNIZATION (one dose on or after 11th birthday)

Tdap

day

year

month

Name	<del></del>			UM Student #		
	Last, Fir	st M. I.				
UBER	RCULOSIS (TB) S	SCREENING (Rea	d Directions Car	efullv)		
lease elow.	complete ONE se	ection below: A or	· B <mark>AND</mark> all stud	ents must comp	lete the annual sympto	om reviev
ection 2-step	TST (Tuberculo	•	TB IGRA (Inter	*	erculosis Infection), t elease Assay) blood t	
ection	<u>a B</u> : If you have a		ive TST (PPD)>		ive IGRA, please sup	ply
out, ca	ın be separated l		f voù have had a	negative PPD	ould be separated by in the last year, pleas	
		Date Placed	Date Read	Result		
	TST step #1			mm	□ Pos □ Neg	
•	TST step #2			mm	□ Pos □ Neg	
Ne	gative IGRA bloo	d test	Date	date year	Copy attached	
ectior elow.	B: If a TB test	(TB skin test or T	TB IGRA blood	test) has been l	POSITIVE anytime,	docume
Po	sitive Tuberculin	Skin Test (TST)	Date	date year		
Pos	sitive IGRA blood	test	Date	date year	Copy attached	
UAL	SYMPTOM REV	IEW:				
Do	you have any of the	he following?				
Cough (	(duration of 3 wks or	more) yes no			no	
Chest P Hemopt Fever	ain tysis (coughing up bl	yes no lood) yes no yes no	Weigh	nt loss yes	no no no	

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Chest X-test)	Ray Requi	red <b>ONLY</b> fo	or those with his	story of posit	ive TB test (Tub	perculin Skin Te	st or IGRA blood
Chest X-	-ray 🗀 N	[ormal =	Abnormal	month	date year		
(A copy	of the chest Y	K-ray report	must be attacl	hed to this fo	orm)		
If TB test	was positive	and chest X-	-ray was negativ	ve: Was treat	ment of latent Th	offered? Ye	s No
Was treat	ment of laten	t Tb accepte	d? ☐ Yes □	Yes			
Γ	Details of trea	tment includ	ing drug, dose, t	frequency, an	d duration:		
	Name & ti	tle of physicia	n or health care p	orovider	Signature	<u>1</u>	Date
	e. If you hat ) ses) shnson (1 dose) doses)			-		ne, but may be copy of record	e a requirement l.
[] Dose 1					□ copy atta	ached	
month	date year						
[] Dose 2							
month	date year						
	hat all dates of physician or			on this form	are correct and	accurate.  Date	
Office Address	SS						
City	State	Zip	Telephone	LICE	ENSE#	Licensed Profes	ssional Signature
	oad completed n to <b>studenthe</b>			documents to	MyUHealthChart.	com. Alternativel	y, you may scan &
Preventable Care Personi 3. CDC Guida	Diseases. Hambornel: Recommenda ance for Evaluating	sky J, Kroger A, V Itions of the Advis 3 Health-	Volfe S, eds. 13th ed. Sory Committee on In	. Washington D.C. mmunization Prac	and Prevention of Vac Public Health Founda tices (ACIP), MMWR, V anagement, MMWR, V	tion, 2015 2. Immuniz /ol 60(7):1-45	ation of Health-

19 4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vo I 67(1):1-31