

**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.**

I. TO BE COMPLETED BY STUDENT (please print)

Name _____
Last, First M. I.

Entering UMMSM: Yr _____

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 _____ copy attached
month day year

Rubella immunity _____ copy attached
month day year

Mumps immunity _____ copy attached
month day year

HEPATITIS B VACCINATION **AND LAB EVIDENCE OF IMMUNITY:**

3 doses of vaccine followed by a **quantitative** Hepatitis B Surface Antibody (titer) drawn at least 4 weeks after 3rd dose. If Hepatitis B Surface Antibody (titer) is negative (<10 IU/ml), please obtain a booster dose and repeat a titer 1-2 months later. Please submit the Medical Student Immunization Addendum **form** to document booster/additional doses.

Of note, needing a second series will NOT delay the start of medical school but must be completed as advised by the health center.

Hepatitis B dose #1 _____ QUANTITATIVE Hep B Surface Antibody positive negative
month day year

dose #2 _____ month day year copy attached
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 apart)
month day year

Varicella immunity _____ copy attached
month day year

TETANUS/ DIPHTHERIA/ PERTUSSIS IMMUNIZATION (one dose on or after 11th birthday)

Tdap _____
month day year

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

TUBERCULOSIS (TB) SCREENING (Read Directions Carefully)

Please complete ONE section below: A or B **AND** all students must complete the annual symptom review below.

Section A: If you do not have a history of TB disease or LTBI (Latent Tuberculosis Infection), the results of a 2-step TST (Tuberculosis Skin Test), or TB IGRA (Interferon Gamma Release Assay) blood test are required, regardless of your prior BCG status.

Section B: If you have a history of a positive TST (PPD)>10mm or a positive IGRA, please supply information regarding further medical evaluation and treatment below.

Section A: Two step Tuberculin Skin Test (TST): Two step PPD's should be separated by 1-3 weeks, but, can be separated by up to a year. If you have had a negative PPD in the last year, please record it as your step 1 below, and obtain another PPD to count as your step 2.

	Date Placed	Date Read	Result	
TST step #1			____ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
TST step #2			____ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg

Negative IGRA blood test Date _____ month _____ date _____ year Copy attached

Section B: If a TB test (TB skin test or TB IGRA blood test) has been POSITIVE anytime, document below.

Positive Tuberculin Skin Test (TST) Date _____ month _____ date _____ year

Positive IGRA blood test Date _____ month _____ date _____ year Copy attached

ANNUAL 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 _____		

