

UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE
IMMUNIZATION RECORD ACADEMIC YEAR 2009-2010

Name		Date	
Allergies		DOB	

TUBERCULOSIS (This test will be repeated when you begin medical school)			
Date of most recent PPD:			
Result of most recent PPD:	Positive:	Negative:	
	If positive: mm induration:		
Have you ever had a positive PPD Conversion?	YES:	NO:	
If YES:	CXR Results: Date:	Normal:	Abnormal:
	Treatment with Anti-tuberculosis medication?	YES:	NO:
	Indicate Which Medications and length of treatment dates:		

IMMUNIZATION RECORD				
You are REQUIRED to show IMMUNITY for the following communicable diseases:				
<i>(NOTE: Female students should discuss vaccinations with their physician if there is any possibility of pregnancy. All immunizations are mandatory for students. Please contact administration to discuss any special circumstances.)</i>				
Hepatitis B:	Hepatitis B Vaccine completed:	YES:	NO:	
	Date of:	1 st Dose:	2 nd Dose:	3 rd Dose:
	Hepatitis BsAb titer positive? (IF KNOWN, NOT REQUIRED) Titer Date:			Titer:
Tetanus/Diphtheria or Tetanus/Diphtheria /Pertussis (circle one)	Booster:	YES:	NO:	Date of last dose:

For each of the following conditions document proof of EITHER Dates of 2 live vaccines OR; Date of recent Vaccine booster OR; Proof of Positive Titer				
	Date of Live Vaccines OR	Date of Vaccine Booster OR	Titer Date (if known)	Positive Titer (indicate value if known)
Measles (Rubeola) **	1 st :			
	2 nd :			
Mumps **	1 st :			
	2 nd :			
Measles (Rubella) **	1 st :			
	2 nd :			
Varicella	1 st :			
	2 nd :			

** List same date if MMR given together

OTHER VACCINE RECORDS (INCLUDE BUT NOT REQUIRED FOR MEDICAL SCHOOL)			
Name of Vaccine	Date of last dose or Series	OR	Date of Last Positive Titer

PHYSICIAN DOCUMENTATION OF STUDENT HEALTH
<p>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 professional judgment that except as noted below, this student is in good health, and has no physical or mental health conditions, or any other impairment that affects, or is reasonably likely to affect, his/her ability to attend medical school.</p>
<p>ADDITIONAL INFORMATION and COMMENTS (use additional sheets if required):</p>

PHYSICIAN NAME (PRINTED): _____ **PHYSICIAN SIGNATURE:** _____

LICENSED IN THE STATE OF: _____ **LICENSE NUMBER:** _____

DATE:	OFFICE ADDRESS:
OFFICE PHONE:	