Immunization Record

Name of Applicant: (PRINT) _____

Date of Birth (YYYY/MM/DD): _____/_____/_____

Toho University Faculty of Medicine requires that all visiting trainees who request enrollment in our clinical electives show proof of a TB test and immunity to measles, mumps and rubella, tetanus/diphtheria and hepatitis B.

Applicants must be free from symptoms of an infectious disease at the start of the elective. Should you become ill with a communicable disease during enrollment, you are REQUIRED to notify your course director/attending physician and remove yourself from patient care activities.

Certification by Physician or School Official

The following information MUST be completed and signed by the applicant's health care facility.

Please check the following immunizations that have been completed by the above named applicant: these immunizations are required for participation in clerkships at Toho University Faculty of Medicine and its affiliated hospitals.

☐ TB SKIN TEST (PPD): within the past 12 months. Date: ____/__/____ Neg ☐ Pos ☐

If the above test result is positive, a chest X-ray is required.

Date: ____/__/____ Results _____

☐ TETANUS/ DIPHTHERIA: Primary series plus TD booster within the last 10 years

TD booster Date: ____/__/____

☐ Measles, Mumps, Rubella, Varicella: 2 doses of vaccination, positive serology, or history of illness diagnosed by a physician(only mumps and varicella) is required.

	Vaccine: 2 doses of vaccination record is required	Positive Serology	History of illness diagnosed by a physician
Measles	Date: ____/__/____ Date: ____/__/____	Date:____/__/____	☐ Not accepted
Rubella	Date: ____/__/____ Date: ____/__/____	Date:____/__/____	☐ Not accepted
Mumps	Date: ____/__/____ Date: ____/__/____	Date:____/__/____	Date:____/__/____
Varicella	Date: ____/__/____ Date: ____/__/____	Date:____/__/____	Date:____/__/____

An applicant who is exposed to chicken pox during clinical clerkship and is not immune will be required to withdraw from all clinical activities.

☐ HEPATITIS B: Series of three doses

Dates: (1)_____/___/_____ (2)_____/___/_____(3)_____/___/_____

Signature (Medical Doctor or Institution Official):_____

Date:_____/___/_____

Name (PRINT or TYPE): _____

Title: _____

Name of School: _____

School Address: _____

_____

Phone: _____ Fax: _____

E-mail: _____