

# Immunization Record

Name of Applicant: (PRINT) \_\_\_\_\_

Date of Birth (YYYY/MM/DD): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Toho University Faculty of Medicine requires that all visiting students 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 student: these immunizations are required for participation in clerkships at Toho University Faculty of Medicine and its affiliated hospitals.

\_\_\_ IGRA blood test 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: _____ / _____ / _____	___ Not accepted
	Date: _____ / _____ / _____		
Rubella	Date: _____ / _____ / _____	Date: _____ / _____ / _____	___ Not accepted
	Date: _____ / _____ / _____		
Mumps	Date: _____ / _____ / _____	Date: _____ / _____ / _____	Date: _____ / _____ / _____
	Date: _____ / _____ / _____		
Varicella	Date: _____ / _____ / _____	Date: _____ / _____ / _____	Date: _____ / _____ / _____
	Date: _____ / _____ / _____		

A student 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 School Official): \_\_\_\_\_

Date:\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name (PRINT or TYPE): \_\_\_\_\_

Title: \_\_\_\_\_

Name of School: \_\_\_\_\_

School Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_