

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 IGRA blood 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 <small>This field cannot be left blank</small>	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: _____