



# THE JIKEI UNIVERSITY SCHOOL OF MEDICINE

3-25-8, Nishi-shimbashi, Minato-ku, Tokyo 105-8461 JAPAN

## Immunisation Form

All applicants must be covered for the vaccinations below. It is not possible for students to have contact with patients until we have received proof that they are immune to the following: Hepatitis B, Tuberculosis, Mumps, Measles, Rubella, and Varicella (Chickenpox).

Family name ..... First name(s) ..... Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

### Details of elective

Attachment 1 From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_ Department \_\_\_\_\_

Attachment 2 From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_ Department \_\_\_\_\_

Attachment 3 From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_ Department \_\_\_\_\_

<b>Hepatitis B</b>	Dates of immunisations _____	Vaccine no. 1 date _____
		Vaccine no. 2 date _____
		Vaccine no. 3 date _____
		Booster date _____
	Results of last blood test _____	Date of last blood test _____
		HB antigen level _____
		HB antibody level _____
<b>Tuberculosis</b>	Date of last heaf or mantoux test _____	
	Result _____	
	Date of BCG vaccination _____	
	Scar present? _____	
<b>Mumps</b>	Date of last blood test _____	
	Results of last blood test _____	
<b>Measles</b>	Date of last blood test _____	
	Results of last blood test _____	
<b>Rubella</b>	Date of last blood test _____	
	Results of last blood test _____	
<b>Varicella (Chickenpox)</b>	Date of last blood test _____	
	Results of last blood test _____	

The above student has had the required vaccinations, or is naturally immune and is not currently suffering from an infectious disease.

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

Name and Address of the Physician \_\_\_\_\_

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