藤田医科大学

Mandatory Immunization Health History Form

国際1-5

FUJITA HEALTH UNIVERSITY HOSPITAL

1-98, Dengakugakubo, Kutsukake-cho, Toyoake, Aichi, 470-1192, JAPAN

All applicants must complete the Mandatory Immunization Health History Form. Students, Trainees and Researchers are not permitted to have contact with patients until we have received proof that they are immune to the followings: mumps, measles, rubella, varicella, tuberculosis, and hepatitis B.

Please email the complete form to the person in charge of your visit at FHU at least 4 weeks prior to the proposed date of placement.

If you have any symptoms, such as fever, cough, diarrhea, vomiting, and rash other than atopic dermatitis, within 72 hours before starting your elective course, also please contact to Center for International Relations. The center will transfer your situations to the hospital.

Applicant Identification

Last Name		First		Middle	
Date of Birth			☐ Male		☐ Female
Name of Institution			Country		
Home address					
Phone Number					
Email address			Date of Entry		
School Entering	☐ Undergraduate ☐ Graduate ☐ Medical ☐ Nursing ☐ Others (____________________________)				
Intended department of elective placement					

Mumps, Measles and Rubella

Please report your immunization record according to either Option 1 or Option 2.
In Option 1, you are required to notify the dates of 2 doses
In Option 2, you are required to notify the dates of 2 doses or the serologic evidence of immunity for each contents to prove that you are vaccinated.
*If you don't have any record of exact dates, input the year or the age you took instead.

Option 1

MMR	☐ Vaccinated	Injection record	Dose #1 Date	Dose #2 Date

Option 2

Mumps	☐ Infected	Do not write here		
	☐ Vaccinated	Injection record	Dose #1 Date	Dose #2 Date
		Serologic Immunity	Titer Result	Examination Date
Measles	☐ Infected	Do not write here		
	☐ Vaccinated	Injection record	Dose #1 Date	Dose #2 Date
		Serologic Immunity	Titer Result	Examination Date
Rubella	☐ Infected	Do not write here		
	☐ Vaccinated	Injection record	Dose #1 Date	Dose #2 Date
		Serologic Immunity	Titer Result	Examination Date

Updated on 2018.April.12

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Varicella (Chikenpox)

You are required to notify the record of 2 doses or serologic proof of immunity to prove that you are vaccinated.

*If you don't have any record of exact dates, input the year or the age you took instead.

Varicella (Chikenpox)	☐ Infected	Do not write here		
	☐ Vaccinated	Injection record	Dose #1 Date	Dose #2 Date
		Serologic Immunity	Titer Result	Examination Date

Hepatitis B

You are required to notify the record of 3 doses or serologic proof of immunity to prove that you are vaccinated.

*If you don't have any record of exact dates, input the year or the age you took instead.

Hepatitis B	☐ Infected	Do not write here			
	☐ Vaccinated	Injection record	Dose #1 Date	Dose #2 Date	Dose #3 Date
		Serologic Immunity	Titer Result	Examination Date	

Tuberculosis Screening

Please report your immunization record in the following item.

*You are required to fill the exact date and result for Chest X-ray.

Images should be taken within 3 months from the date of arrival.

＜Mandatory＞ Chest X-ray(if positive PPD or lab)	Date	Result		
<Optional> TB Skin Test by TST	Date Placed	Date Read	MM	☐Neg ☐Pos
<Optional>	Date	Result		

If you would like to inform us about your health condition (such as history of anaphylactic shock, having food allergy, asthma, epilepsy, type I diabetes, cardiomyopathy, arrhythmia, sickle cell anemia, mental disease, and other specific diseases) or about any medicine in use, please provide information it in the following space.

Signature of elective student		Date	
Signature of physician		Date	