Keio University School of Medicine
International Clinical Elective Program Application Form

Immunization Record

Name: Sex:

Date of Birth: Email:

(Please write all dates as mm/dd/yyyy)

1. Tuberculosis Screening (PPD or IGRA (QFT, T-spot)) *within last 12 months*

Test (circle one): **PPD / IGRA (QFT, T-spot)** Date:
Result (circle one): **Negative / Positive**

If PPD or IGRA (QFT, T-spot) *is positive, a chest X-ray is required.*

X-ray Date: Result:

2. Tetanus / Diphtheria (primary series plus booster *within last 10 years)*

Year of the end of primary series:
Date of Booster:

3. Hepatitis B (series of three doses)

Date of 1st dose:
Date of 2nd dose:
Date of 3rd dose:

If available, state your HBsAb titer.

Test date: HBsAb titer (IU/l):

4. Measles, Mumps, Rubella, Varicella; Vaccination OR Positive Serology *within last 5 years*

Measles:	Vaccination (Date:	)	OR Positive Serology (Date:	)
Mumps:	Vaccination (Date:	)	OR Positive Serology (Date:	)
Rubella:	Vaccination (Date:	)	OR Positive Serology (Date:	)
Varicella:	Vaccination (Date:	)	OR Positive Serology (Date:	)

_____ _____
Signature of Supervising Physician Date

_____
Print Name

_____
Hospital / Institution Name and Address