



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 Immunization demonstrated by ONE of the following three options:

- ◆ Date of Vaccination (within last 5 years before the start of your program)
- ◆ Date of Positive Serology (within last 5 years before the start of your program)
- ◆ Dates of 2 Vaccinations (administered at any time)

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