Immunization Record (International Student)

Name	Katakana Name	Email

Measles, Mumps, Rubella, Varicella (MMRV): Please fill out section (1) or (2) for each disease.

(1) History of viral vaccination (2 Inoculations)

Date of Vaccination	Measles	Mumps	Rubella	Varicella
① (YYYY-MM-DD)				
② (YYYY-MM-DD)				

(2) Antibody Test Results and Related Immunization History

	Measles	Mumps	Rubella	Varicella
Date of Testing (YYYY-MM-DD)				
Method (circle method)	IgG(EIA) / NT	IgG(EIA)	IgG(EIA) / HI	IgG(EIA) / IAHA
Measurement values				
Result (circle result)	Negative / Positive / Strongly Positive	Negative / Positive / Strongly Positive	Negative / Positive / Strongly Positive	Negative / Positive / Strongly Positive
Date of Vaccination ① (YYYY-MM-DD)				
Date of Vaccination ② (YYYY-MM-DD)				

Hepatitis B: Please fill in only if the applicant is engaged in work or research that may involve exposure to body fluids, such as the handling of instruments or medical waste contaminated with body fluids, treatments involving contact with body fluids, blood sampling, testing, or specimen handling.

(1) 3-dose primary vaccination series

	①	②	③	If unknown:
Date of Vaccination (YYYY-MM-DD)				(approx. year)

(2) Have the applicant ever had a positive HBs antibody test result (10mIU/mL or more) after receiving a primary vaccination series or booster dose?

☐ **Yes** ☐ **No**

(3) If the answer to (2) is "Yes", please fill in the box below:

Date of Testing (YYYY-MM-DD)	**Method** (circle method)	**Measurement values**
	CLEIA / CLIA	mIU/ml

(4) If the answer to (2) is "No", the applicant may have insufficient immunity to hepatitis B. The applicant must consult a medical institution regarding additional booster doses and submit this certificate after consultation.

For the Health Care Provider:

Before creating this certificate, please refer to the applicant's Maternal and Child Health Handbook, antibody test results, and vaccination certificates, and confirm that the applicant meet the standards of our hospital.

<MMRV> Applicant must meet one of the following conditions ①–③ for each MMRV disease:

① Proof of two previous vaccinations

② Proof of previous positive antibody test results (any year) and proof of a subsequent vaccination

③ Proof of previous strongly positive antibody test results (any year)

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<Hepatitis B> Applicants must meet the following condition:

《Only required for those engaged in work or research that may involve exposure to body fluids, such as the handling of instruments or medical waste contaminated with body fluids, treatments involving contact with body fluids, blood sampling, testing, or specimen handling.》

The applicant has already received a hepatitis B primary vaccination series and has confirmed an antibody titer of ≧10 mIU/ml (CLEIA/CLIA) considered a reliable marker of protection against infection.

※Consult the table below for definitions of negative, positive, and strongly positive MMRV results.
※Antibody testing is valid for the following methods only:
Measles: IgG-antibody titer determined by enzyme-immunoassay (EIA) or neutralizing antibody titer (NT)
Mumps: IgG-antibody titer determined by enzyme-immunoassay (EIA)
Rubella: IgG-antibody titer determined by enzyme-immunoassay (EIA) or hemagglutination inhibition (HI) antibody titer
Varicella: IgG-antibody titer determined by enzyme-immunoassay (EIA) or immune adherence hemagglutination (IAHA) titer

Antibody titer / Disease	Negative		Positive		Strongly Positive	
	EIA	Other	EIA	Other	EIA	Other
Measles	below **2.0**	NT of less than **4**	2.0-15.9	NT of **4**	**16.0** or higher	NT of **8** or higher
Mumps	below **2.0**	–	2.0-3.9	–	**4.0** or higher	–
Rubella	below **2.0**	HI titer of less than **8**	2.0-7.9	HI titer of **8-16**	**8.0** or higher	HI titer of **32** or higher
Varicella	below **2.0**	IAHA titer of less than **2**	2.0-3.9	IAHA titer of **2**	**4.0** or higher	IAHA titer of **4** or higher
Vaccination series	**2 doses** of vaccine following examination		**1 dose** of vaccine following examination		Vaccination not required	

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

(1) Please fill in the box below.

Date of Testing (YYYY-MM-DD)	**Method** (circle method)	**Result** (circle result)
	PPD / IGRA (QFT , T-spot)	Negative / Positive

(2) If PPD or IGRA (QFT, T-spot) is positive, a chest X-ray is required. Please fill in the box below.

Date of X-ray (YYYY-MM-DD)	**Result**

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

Please fill in the box below.

Date of Vaccination (YYYY-MM-DD)	**Date of Booster** (YYYY-MM-DD)

※ If the applicant cannot receive the vaccination due to allergies, pregnancy, etc., or if the applicant is a vaccine non-responder, please indicate so in the notes section.

Notes:

I certify that the above information is accurate to the best of my knowledge.

Date: Name of Health Care Provider / Address;

Physician Name;

【Personal information is shared between the International Office, the Health Center, and the Center for Infectious Disease and Infection Control; and as a rule is not shared with any third parties. However, in exceptional circumstances such as urgent situations regarding hospital infection; complying with law; or situations in which it is necessary to protect an individual's life, property, or wellbeing; personal information may be shared with third parties without the individual's consent. Data (except identifying personal information) may be used for education, research, or lectures.】