Immunization Record

Mahidol University

All visiting students/medical students/doctors who apply for an elective/short course study are required to show proof of health insurance and each of the immunizations indicated in this document.

Section I	**PERSONAL INFORMATION**

Name.....

Date of Birth..... **Age**..... **Sex** ☐ Male ☐ Female

Passport Country.....

School/Medical School/University.....

Category ☐ Student ☐ Resident Doctor ☐ Fellowship Doctor

☐ Trainer ☐ Researcher ☐ Other.....

Section II	**PROOF OF IMMUNIZATION** Please give us for information on the required test result, Vaccinations and immunizations. Also give dates in appropriate column.

1. MMR: Mumps, Measles and Rubella

☐ Mumps	Vaccine	Date.....	Or	Positive Serology	Date.....
☐ Rubeola (Measles)		Date.....			Date.....
☐ Rubella (German Measles)		Date.....			Date.....

2. Varicella (Chickenpox)

☐ Ab Screening date ☐ Positive IgG Ab (immuned)

☐ Negative IgG Ab: immunization on date (1).....

date (2).....

3. Diphtheria, Pertussis, Tetanus and Poliomyelitis (primary series booster within the last 10 years)

Immunization or booster			
☐ Diphtheria	Date.....	☐ Tetanus	Date.....
☐ Pertussis	Date.....	☐ Poliomyelitis	Date.....

4. Hepatitis Series (Hepatitis C Virus, HCV and Hepatitis B Virus, HBV)

☐ Screening date..... ☐ HBsAg.....

☐ Anti HBsAnti.....

☐ HCV.....

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5. Influenza Vaccine

☐ Yes, please specify date;.....

☐ No

6. Tuberculosis Screening (within the past 6 months)

☐ Mantoux/PPD Test	Date.....	Result ☐ Positive ☐ Negative
☐ IGRA Test*	Date.....	Result ☐ Positive ☐ Negative
☐ Chest X-ray	Date.....	Result ☐ Positive ☐ Negative

*IGRA Test or Chest X-ray is only necessary in case of a positive Mantoux/PPD Test

7. Chest X-ray (Attached document, not the film, is required)

☐ Normal, Date..... ☐ Others Date.....

Described .....

8. Medical certificate from a certified physician or a certified health care provider (Attached document is required)

****I, HEREBY, GIVE A PERMISSION FOR THE FACULTY OF MEDICINE RAMATHIBODI HOSPITAL, MAHIDOL UNIVERSITY TO USE THE ABOVE INFORMATION IN ORDER TO CONSIDER MY ADMISSION FOR SHORT-TERM STUDY****

Signature..... **Date**.....

Printed Name.....

9. Certification by Physician (This is only necessary in case of you don't have document for 1-8)

Name..... Signature.....

Holding medical license no. ..... Date.....

Name of hospital and seal.....