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| Immunization Record  &  Certificate of Health | | **International Centre, Momoyama Gakuin University**  For Momoyama use only  Student ID  1-1 Manabino Izumi, Osaka 594-1198  Phone: +81-(0)725-54-3131 Fax: +81-(0)725-54-3215 |
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| Exchange students must provide proof of compliance with immunization requirements of the Preventive Vaccination Law and The Tuberculosis Control Law. Students who fail to comply with this requirement will not be able to enroll for courses the following semester. Enter all information in English formats. | | |
| * PART1. TO BE COMPLETED BY THE STUDENT – PLEASE PRINT | | |
| Last Name First Name Date of Birth Semester & Year first enrolled | | |
| Current Address 　　　　　　　　 County 　 Phone Number | | |
|  | | |
| TO THE PHYSICIAN:  Please review the information provided on this form and answer the following questions. Where appropriate, we ask that you send a clinical report to assist us in responding to your recommendations. Thank you.   * PART2. REQUIRED IMMUNIZATIONS | | |
| VACCINES | DATE ADMINISTERED (DD/MM/YY) | |
| MMR　（Measles、Mumps、Rubella）：2 doses  Required at least 1 month apart  Or ALL 3 OF THESE CRITERIA ARE MET:  Measles  Mumps  Rubella | (1)\_\_\_ / \_\_\_ / \_\_\_ (2)\_\_\_ / \_\_\_ / \_\_\_  OR copy of titer indicating positive immunity  (1)\_\_\_ / \_\_\_ / \_\_\_ (2)\_\_\_ / \_\_\_ / \_\_\_ OR copy of titer indicating positive immunity  (1)\_\_\_ / \_\_\_ / \_\_\_ (2)\_\_\_ / \_\_\_ / \_\_\_ OR copy of titer indicating positive immunity  (1)\_\_\_ / \_\_\_ / \_\_\_ (2)\_\_\_ / \_\_\_ / \_\_\_ OR copy of titer indicating positive immunity | |
| Diphtheria、Pertussis、Tetanus、 | (1)\_\_\_ / \_\_\_ / \_\_\_ (2)\_\_\_ / \_\_\_ / \_\_\_ (3)\_\_\_ / \_\_\_ / \_\_\_  (4)\_\_\_ / \_\_\_ / \_\_\_ (5)\_\_\_ / \_\_\_ / \_\_\_  OR copy of titer indicating positive immunity | |
| Polio | (1)\_\_\_ / \_\_\_ / \_\_\_ (2)\_\_\_ / \_\_\_ / \_\_\_ (3)\_\_\_ / \_\_\_ / \_\_\_　(4)\_\_\_ / \_\_\_ / \_\_\_  OR copy of titer indicating positive immunity | |
| Tetanus―Diphtheria  Booster within past 10 years | (1)\_\_\_ / \_\_\_ / \_\_\_ OR copy of titer indicating positive immunity | |
| * PART3. RECOMMENDED VACCINATIONS  |  |  | | --- | --- | | VACCINES | DATE ADMINISTERED (MM/DD/YY) | | Varicella(chicken Pox) | 1. \_\_\_ / \_\_\_ / \_\_\_ (2)\_\_\_ / \_\_\_ / \_\_\_   OR copy of titer indicating positive immunity |   Transcribed records　　 Gave Vaccine to student   * PART4. PHYSICAL EXAMINATION : TO BE COMPLETED BY THE PHYSICIAN   1.Height: cm 2.Weight: kg 3.Blood Type  RH　+　－  A・B・O・AB  4. Chest X-Ray Examination (within 6 months from application starting date)  Lung : □normal　　□impaired Cardiomegaly : □normal　　□impaired  Date: / /  5.Tuberculosis (TB) screening (Blood test or Skin test)   * Blood test   T-Spot : Date / / Results; □ Negative □ Positive  QFT : Date / / Results; □ Negative □ Positive   * Skin Test : Date / / Results; □ Negative □ Positive ( mm)   6. Disease Being Treated at Present? □No  □Yes (Disease: ) （Essential medication:　　 　　　　　　　　 ）  7. Allergies? □No □Yes (If yes, please list causes/triggers )  8. Past history :Please indicate with “+” or “－” in each box and fill in the date of recovery where applicable  Tuberculosis.....□( . . ) Malaria.......□( . . ) Other communicable disease......□( . . )  Epilepsy......□( . . ) Kidney Disease.....□( . . ) Heart Diseases......□( . . )  Diabetes......□( . . ) Drug Allergy......□( . . ) Asthma.....□( . . ) Psychosis.....□( . . )  9. In view of the applicant’s history and the above findings, is it your conclusion that his/her health status is adequate to pursue studies in Japan ? Yes□ No□  Particular notes or additional comments：  Date: / / Physician’s Signature: | | |
| Physician’s Name (Print):  Office/Institution  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  　　　　Phone Number:  E-mail: | | |