



Seoul National University Health Form

Address

Name (please print): _____
Last First Middle
Date of Birth : ____/____/____ Nationality : _____
Email : _____ Telephone : _____

Seoul National University requires all students to be immunized against certain communicable diseases. To comply have this form completed and signed by your health care provider and submitted to the above address as soon as possible and no later than (마감일자). Alternatively you may fax completed forms to (FAX 번호).

1. Immunizations

| Required | Dates Given (Month/Day/Year) | Requirements |
|--|--|--|
| Measles-Mumps-Rubella (MMR) If administered separately or positive titers obtained, record below | #1 ____/____/____ #2 ____/____/____ month day year month day year | Two doses at age ≥ 12 months, at least 28 days apart. History of disease is not acceptable |
| Measles (Rubeola) | Date #1 ____/____/____ #2 ____/____/____ OR Positive titer _____ Date: ____/____/____ | Two doses or positive titer |
| Mump | Date #1 ____/____/____ #2 ____/____/____ OR Positive titer _____ Date: ____/____/____ | Two doses or positive titer |
| Rubella (German Measles) | Date #1 ____/____/____ #2 ____/____/____ OR Positive titer _____ Date: ____/____/____ | Two doses or positive titer |
| Recommended* | Dates Given (Month/Day/Year) | Recommends |
| Varicella | Date #1 ____/____/____ #2 ____/____/____ OR Positive titer _____ Date: ____/____/____ | Two doses at age ≥ 12 months, at least 28 days apart. |
| Tetanus/Diphtheria/Pertussis (Tdap) | Date: ____/____/____ | One dose within the past 10 years |
| Hepatitis B | #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ | Dose #1, any age Dose #2, 1-2 months after dose #1 Dose #3, 6 months after dose #1 |
| Hepatitis A | #1 ____/____/____ #2 ____/____/____ | Dose #2, 6 months after dose #1 |
| Meningococcal | Date: ____/____/____ | |

* Recommended vaccinations are available at SNU Health Service Center at own expense after arrival. Required vaccinations should be given prior to arrival.

2. Tuberculosis Screening

PPD or chest X-ray (CXR) must be done **within one calendar year** prior to your Seoul National University admittance. History of BCG vaccination does not prevent PPD testing.

PPD: Date placed ____/____/____ Date read ____/____/____ # of mm induration _____ Negative Positive
If PPD results are 10mm or more, a chest X-ray is REQUIRED.

Chest X-ray: Date ____/____/____ Result: Normal Abnormal → Finding: _____
Please attach chest X-ray report in English

If PPD test is/was positive or CXR is positive, did student complete a course of antibiotic therapy?

- YES _____
Drug, Dose, Frequency, Duration and Dates
- NO _____
Please document reason prophylaxis or treatment not done

PROVIDER INFORMATION REQUIRED

Signature of health care provider _____ Physician/Medical provider Name (please print) _____ Date _____

Clinic/Institution: _____

Address: _____

Phone number: _____ Fax number: _____