Seoul National University Health Form

Name (please print): _____ _____ _____
Last First Middle

Date of Birth : ____/____/____ Nationality : _____

Email : _____ Telephone : _____

Address

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:_____