Seoul National University BK Residence Halls

Health Certificate

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

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

Email : _____ Telephone : _____

Seoul National University requires all residents to be immunized against certain communicable diseases. To comply, have this form completed, signed and sealed with an official seal of the institutuion by your health care provider. **Only the original copy of this form will be valid.**

1. Immunizations

Required	Dates Given (Month/Day/Year)	Requirements
Measles-Mumps-Rubella (MMR) If administered separately or positive titers obtained, record below	#1____/____/____ (month day year) #2____/____/____ (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

※ **Only residents with their 2nd dose of MMR or Measles vaccination will be admitted to the BK Residence Halls.**

2. Tuberculosis Screening

PPD or chest X-ray (CXR) must be done **within six months** prior to your official move-in date.
History of BCG vaccination does not prevent Tuberculosis screening.
SNU BK Residence Halls accepts either PPD or Chest X-ray as valid tests for tuberculosis screening.
Only one of the two tests needs to be initially performed.

Chest X-ray: Date____/____/____ Result: ☐ Normal ☐ Abnormal → Finding:_____
Please attach chest X-ray report in English
If the Chest x-ray is found to be Abnormal, a PPD test is REQUIRED.

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

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

☐ YES _____
Drug, Dose, Frequency, Duration and Dates

Please attach a document of a follow up tuberculosis screening completed after the antibiotic therapy that shows either a negative PPD or normal CXR result.

PROVIDER INFORMATION REQUIRED

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

Clinic/Institution:_____

Address:_____

Phone number:_____ Fax number:_____

Official Seal of the Institution: