



# 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
<b>Measles-Mumps-Rubella (MMR)</b> 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: \_\_\_\_\_