POZNAN UNIVERSITY OF MEDICAL SCIENCES

CENTER FOR MEDICAL EDUCATION IN ENGLISH

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STUDENT'S NAME: **D.O.B.**: **ID#**:

Measles: Proof of immunity to measles means two doses of live vaccine administered on or after 12 months of age, separated by at least one month and/or serologic evidence of immunity.
Primary Vaccinations #1 Date:____/____/____
#2 Date:____/____/____
OR Positive Titer Date:____/____/____ Result:
OR Additional Vaccination Date:____/____/____

STAMP/SIGNATURE

Mumps: Proof of immunity means one dose of mumps vaccine administered on or after the first birthday and/or serologic evidence of immunity.
Primary Vaccination #1 Date:____/____/____
OR Positive Titer Date:____/____/____ Result:
OR Additional Vaccination Date:____/____/____

STAMP/SIGNATURE

Rubella: Proof of immunity means one dose of rubella vaccine administered on or after the first birthday and/or serologic evidence of immunity.
Primary Vaccination #1 Date:____/____/____
OR Positive Titer Date:____/____/____ Result:
OR Additional Vaccination Date:____/____/____

STAMP/SIGNATURE

Varicella: Documented history of Varicella: ?Yes ?No Date:____/____/____
If No: Varicella Titer: Date:____/____/____ Result:
If negative titer, two vaccinations required: #1 Date:____/____/____ #2 Date:____/____/____

STAMP/SIGNATURE

Tetanus/Diphtheria: Primary series plus Td booster within last 10 years Date:____/____/____

STAMP/SIGNATURE

Hepatitis B:
Vaccine series completed: 1st Date:____/____/____2nd Date:____/____/____3rd Date:____/____/____
Hepatitis B Surface Ab Titer: Date:____/____/____ Result:

STAMP/SIGNATURE

PPD Tuberculin Test:
Date: (within six months) ____/____/____ ?Negative ?Positive Result: _____mm
If above test positive, a chest x-ray required Date:____/____/____ Result: _____

STAMP/SIGNATURE

OTHER:

Hepatitis A: #1 Date:____/____/____ #2 Date:____/____/____
Polio: series of 4 completed, last dose: Date:____/____/____
Meningococcal: Date:____/____/____

STAMP/SIGNATURE