THE JIKEI UNIVERSITY SCHOOL OF MEDICINE
3-25-8, Nishi-Shimbashi, Minato-ku, Tokyo 105-8461 Japan

Immunisation and Health Screening Form

All applicants must complete the Immunisation and Health Screening Form. Students are not allowed to have contact with patients until we have received proof that they are immune to the followings: Mumps, Measles, Rubella, Varicella, Tuberculosis and Hepatitis B.

Part1, 2, and 3 must be sumitted with your application form.
Part 4 must be sumitted no later than 1 month before your arrival in Japan.
Send to: elective@jikei.ac.jp

PART I: : To be completed by the visitor/observer

First name _____ Surname _____

Date of Birth(mm/dd/yyyy) _____ ☐ Male ☐ Female

Name of University _____

E-mail address _____

Home address _____

Intended department of elective placement _____

Date of placement _____

Have you been exposed to a disease listed in the following homepage?

https://www.mhlw.go.jp/english/wp/wp-hw4/dl/health_and_medical_services/P79.pdf

YES ☐ NO☐

In case of yes, please provide the information in detail.

_____

_____

If you would like to inform us about your health condition, such as history of anaphylactic shock, having food allergy, asthma, epilepsy, type I diabetes, cardiomyopathy, arrhythmia, sickle cell anemia, mental disease and other specific diseases, or about any medicine in use, please describe it in the space below.

_____

_____

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PART II: To be completed and signed by a physician.
Tick appropriate box. ☑

MEASLES: Two doses of Measles vaccine or positive serology through a blood test

☐ Immunisation with two doses of live virus vaccine
Vaccine 1 Date (mm/dd/yyyy):
Vaccine 2 Date (mm/dd/yyyy):

☐ Positive serology confirmed
Tick one of the methods below (EIA is recommended), and please specify the result in figures.
☐ EIA ☐ PA ☐ NT Laboratory Result : _____ Test Date:

MUMPS : Two doses of Mumps vaccine or serologic evidence of immunity through a blood test

1. Immunsation with two doses of live virus vaccine? □
Dates given mm dd yyyy Dose 1 _____/_____/_____
Dates given mm dd yyyy Dose 2 _____/_____/_____

2. Immunity confirmed by blood titer? □
Inspection method and result
EIA □ Laboratory Result: _____ Test Date:

RUBELLA : Two doses of Rubella vaccine or serologic evidence of immunity through a blood test

1. Immunisation with two doses of live virus vaccine? □
Dates given mm dd yyyy Dose 1 _____/_____/_____
Dates given mm dd yyyy Dose 2 _____/_____/_____

2. Immunity confirmed by blood titer? □
Choose one of the methods below (EIA is recommended) and please specify the result in figures.
EIA □ HI □ Result : _____ Date Performed _____/_____/_____

VARICELLA: Two doses of Varicella vaccine or serologic evidence of immunity through a blood test

1. Immunisation with two doses of live virus vaccine? □
Dates given mm dd yyyy Dose 1 _____/_____/_____
Dates given mm dd yyyy Dose 2 _____/_____/_____

2. Immunity confirmed by blood titer? □
Choose one of the methods below (EIA is recommended), and please specify the result in figures.
EIA □ IAHA □ NT □ Result : _____ Date Performed _____/_____/_____

HEPATITIS B: Serologic evidence of immunity through a blood test

Immunity confirmed by blood titer □
(> 10mIU/mL required) anti-HBs titer : _____ Date Performed _____/_____/_____

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PART III To be completed and signed by a physician.
All dates must include month, day and year. Tick appropriate box.

1. Are you from a country with a high risk of tuberculosis? YES ☐ NO☐

   Please refer to the WHO website. https://www.who.int/teams/global-tuberculosis-programme/data

   A rate of 40 per 100,000 or more is considered to be a high indicate of tuberculosis.

2. Have you ever had close contact with a person who has active tuberculosis? YES ☐ NO☐

Please Note: Before your arrival (prefer to part IV),
you must submit the results of an interferon-based assay tuberculosis blood test OR a chest radiograph.

Please review the information above and sign below.

I hereby verify that the information provided on this form (Part I - III) is accurate, to the best of my knowledge.

Signature _____ Date _____

Print name / in block letters _____

Hospital/ Institution name and address (Must be a physician at the student's institution) _____

Contact e-mail address _____

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PART IV This final part must be sent to elective@jikei.ac.jp **no later than 1 month before your arrival** in Japan.
You must submit the results of either ① or ②.
If you fail to submit this form on time, your participation in the elective will be automatically cancelled.

① Quantiferon Gold Test or T-Spot Test Date: _____/_____/_____ Result_____
mm dd yyyy

＊Interferon-based Assay TB Blood Test (IGRA) within the last 12 months.

② Chest X-ray Date performed : _____/_____/_____ Result_____
mm dd yyyy

＊A chest radiograph must be taken and examined for diagnosis within 2 months before your arrival date in Japan.

Please review the information above and sign below.

① Quantiferon Gold Test or T-Spot must be signed a physician at the student's institution,
② Chest X-ray must be signed by a clinician specializing in radiology, infectious diseases at the student's institution.

I hereby verify that the information provided on this form (Part IV) is accurate, to the best of my knowledge.

Signature Date

Print name in block letters

Hospital/Institution name and address (Must be a physician at the student's institution)

Contact e-mail address

Please note if you have symptoms of possible infectious disease when starting your elective,
your elective might be cancelled/terminated after consultation with a specialist.