



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 submitted with your application form.

Part 4 must be submitted 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)	_____	<input type="checkbox"/> Male	<input type="checkbox"/> 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. 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? ☐

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 (refer 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

