SHINSHU UNIVERSITY | School of Medicine
Graduate School of Medicine

IMMUNIZATION HEALTH HISTORY（IHH）

Please complete this form below, attach a copy of supporting documentation if available (i.e. immunization records, lab results etc.) .

NAME:_____(M / F) Date of Birth:_____ Grade:_____

HOME INSTITUTION: _____ COUNTRY:_____

This is to certify that the above mentioned has the following immunization status.

DISEASE	IMMUNIZATION REQUIREMENT	Please complete the sections below.
Measles	2 doses of vaccine OR positive titer* to measles (*≥1:8(NT), ≥1:256(PA), or ≥16.0(IgG EIA)) 1 booster dose is required IF titer is weakly positive** (**1:4(NT), 1:16-1:128(PA), or ±(IgG EIA))	If you have received vaccine, please list the date(s) of vaccination: Dose #1:_____ Dose #2:_____ If you have titer result, please list: Date:_____ Result/Method:_____
Mumps	2 doses of vaccine OR positive titer* to mumps (*+(IgG EIA)) 1 booster dose is required IF titer is weakly positive** (** ±(IgG EIA))	If you have received vaccine, please list the date(s) of vaccination: Dose #1:_____ Dose #2:_____ If you have titer result, please list: Date:_____ Result/Method:_____
Rubella	2 doses of vaccine OR positive titer* to rubella (* ≥1:32(HI） or ≥8.0(IgG EIA)) 1 booster dose is required IF titer is weakly positive** (** 1:8- 1:16(HI) or ±(IgG EIA))	If you have received vaccine, please list the date(s) of vaccination: Dose #1:_____ Dose #2:_____ If you have titer result, please list: Date:_____ Result/Method:_____
Varicella (Chickenpox)	2 doses of vaccine OR positive titer* to varicella (*≥1:8(IAHA), +(IgG EIA), or + skin test) 1 booster dose is required IF titer is weakly positive** (** 1:2- 1:4(HI) or ±(IgG EIA))	If you have received vaccine, please list the date(s) of vaccination: Dose #1:_____ Dose #2:_____ If you have titer result, please list: Date:_____ Result/Method:_____
TB (Tuberculosis)	Baseline 1-step TB skin test (TST) within the last 12 months If positive TST, documentation of a normal chest x-ray	Date of TST: _____ Result:_____ If positive TST: Date of x-ray:_____ Result:_____
Hepatitis B	positive HBs antibody at least 1 month after completion of 3 consecutive doses of vaccination	Date of test:_____ Result/Method:_____

Signature of physician:_____Date:_____