Health Assessment Form

Please complete a table below giving dates of immunization OR dates of antibody tests, methods and results. You may be asked to attach copies of relevant test results. The signature of a physician must be included in this documentation.

Your Name: _____

Your Institute:_____

	Date of vaccine given	**Date of test**	**Method (eg; EIA, PA)**	**Result (value)**
Measles	Dose1 ____/____/____ Date Month Year Dose2 ____/____/____ Date Month Year	____/____/____ Date Month Year		
Rubella	Dose1 ____/____/____ Date Month Year Dose2 ____/____/____ Date Month Year	____/____/____ Date Month Year		
Varicella	Dose1 ____/____/____ Date Month Year Dose2 ____/____/____ Date Month Year	____/____/____ Date Month Year		
Mumps	Dose1 ____/____/____ Date Month Year Dose2 ____/____/____ Date Month Year	____/____/____ Date Month Year		
Hepatitis B (Anti-HBs)	Dose1 ____/____/____ Date Month Year Dose2 ____/____/____ Date Month Year Dose3 ____/____/____ Date Month Year	____/____/____ Date Month Year		
	Date of Test	**Result**		
Chest X-ray Requirement	_____/_____/_____ Date Month Year	☐ Revealed no abnormalities ☐ Other Comments:_____		

*Please refer to cut values for immunity test in the Table 1

I hereby acknowledge that this document and any source of information provided in this document are an accurate representation of this person's current immunization status.

Institution:_____

Print Name or Physician:_____

Signature of Physician _____ **Date:**_____
(DD/MM/YY)

Immunization Requirements
Kobe University Hospital

Please provide information about your immunity status by filling the table in Health Assessment Form. A signature of the doctor will be required on the documentation.

1. Measles, Rubella, Varicella (chicken pox), and Mumps

Please provide either of [1] or [2] as proofs of immunization against measles, rubella, varicella and mumps.

[1] A history of two doses of vaccine. Please provide dates of each vaccine received.

[2] Results of antibody tests issued within past five years recording date and method.
Please refer to acceptable antibody level in Table 1

Table 1

	Acceptable level of antibody titer
Measles	IgG-EIA: ≥16.0 PA: ≥256 NT: ≥8
Rubella	IgG-EIA: ≥8.0 HI: ≥32
Varicella (chicken pox)	IgG-EIA: ≥4.0
Mumps	IgG-EIA: ≥4.0

Note: Applicants whose immunity is below satisfactory level yet unable to receive vaccines with compelling reason should provide a written document indicating the reason. The document must be signed by physician.

2. Hepatitis B

Response to the vaccine using the 0, 1 and 6 months vaccination schedule for hepatitis B should be checked by an antibody test (anti-HBs) taken a month after the third injection. A level of 10 mIU/mL or more is acceptable. Please consult us if your immunity level is below the satisfactory level having completed two or three hepatitis B series.

3. Chest X-Ray

X-Ray should be taken within the past 12 months.

*Your application may be declined to prevent nosocomial infection if information is not accurate.