



Faculty of Medicine, Chiang Mai University

Immunization Record

Name of Applicant: _____

Date of Birth: _____
MM / DD / YY

Faculty of Medicine, Chiang Mai University requires that all visiting students who request enrollment in our clinical electives and clinical attachments show proof of vaccination against measles, mumps, rubella, chicken pox, influenza, hepatitis B, Tuberculosis, Meningococcal etc.

Applicants must be free from symptoms of an infectious disease at the start of the elective. Should you become ill with a communicable disease during enrollment, you are REQUIRED to notify your course director/attending physician and remove yourself from patient care activities.

The following information MUST be completed and signed by the applicant's health care facility.

MMR #1 ____/____/____

(Given after 1 year of age)

Measles #1 ____/____/____

Mumps #1 ____/____/____

Rubella #1 ____/____/____

MMR #2 ____/____/____

(Given 30 days after Dose 1) -or-

Measles #2 ____/____/____

Mumps #2 ____/____/____

Rubella #2 ____/____/____

-or- Immunizations that do not follow the above schedule must be accompanied by a lab report showing positive immunity.

Tetanus/Diphtheria ____/____/____ or
or Tdap vaccine ____/____/____

Tetanus/Diphtheria/Pertussis ____/____/____

(Given in the last 10 years and it must stay current while the student is enrolled at the University)

If the student has not had this vaccine in the past 10 years then a booster must be given.

Varicella #1 ____/____/____ (Given after 1 year of age)

Varicella #2 ____/____/____ (Given 30 days after Dose 1)

-or-

History of Disease ____/____ (month/year) Documented by a Medical Provider

-or-

Immunizations that do not follow the above schedule must be accompanied by a lab report showing positive immunity

Chest X-ray and result

Date: ____/____/____ Results _____

(the chest X-ray results three months before starting the elective preceptorship.)

Hepatitis B #1 ____/____/____		Hepatitis B #2 ____/____/____ (Given 4 weeks after Dose 1)
Hepatitis B #3 ____/____/____ (Given 16 weeks after Dose 1 and 8 weeks after Dose 2)		
-or- Immunizations that do not follow the above schedule must be accompanied by a lab report showing positive immunity.		
Influenza ____/____/____	Students coming and staying from July to the end of March are strongly advised to take this vaccination	

Signature (Medical Doctor or School Official): _____

Date: ____/____/____

Name (PRINT or TYPE): _____

Title: _____

Name of School: _____

School Address: _____

Phone: _____ Fax: _____

E-mail: _____

Office stamp