**IMMUNIZATION RECORD** **St. Luke's International Hospital**

**PART I** : To be completed by the **visitor/observer**. （Please Print）

| Name (Last): | First: |
|---|---|
| Date of Birth (mm/dd/yyyy): | Email Address: |

Address:

| Number and Street | City | Zip | Country |
|---|---|---|---|

**PART II:** To be completed and signed by a physician, nurse practitioner or physician's assistant.
All dates must include month, day and year. (Check appropriate box.)

**MEASLES:**
Two doses of MMR **OR** two doses of individual measles vaccine **OR** sserologic evidence of immunity through a blood test

1. Immunization with **TWO(2)** doses of live virus vaccine? ☐

Dates given mm dd yyyy mm dd yyyy
Dose1 ______/______/______ Dose2 ______/______/______

| 2. Immunity confirmed by blood titer? ☐ | Date Performed ______/______/______ |
|---|---|
| 3. Exemption? ☐ | Attach signed statement |

**MUMPS :**
Two doses of MMR **OR** two doses of individual mumps vaccine **OR** sserologic evidence of immunity through a blood test

1. Immunization with **TWO(2)** doses of live virus vaccine? ☐

Dates given mm dd yyyy mm dd yyyy
Dose1 ______/______/______ Dose2 ______/______/______

| 2. Immunity confirmed by blood titer? ☐ | Date Performed ______/______/______ |
|---|---|
| 3. Exemption? ☐ | Attach signed statement |

**RUBELLA:**
Two doses of MMR **OR** two doses of individual rubella vaccine **OR** sserologic evidence of immunity through a blood test

1. Immunization with **TWO(2)** doses of live virus vaccine? ☐

Dates given mm dd yyyy mm dd yyyy
Dose1 ______/______/______ Dose2 ______/______/______

| 2. Immunity confirmed by blood titer? ☐ | Date Performed ______/______/______ |
|---|---|
| 3. Exemption? ☐ | Attach signed statement |

**VARICELLA:** Two doses of varicella vaccine **OR** sserologic evidence of immunity through a blood test

1. Immunization with **TWO(2)** doses of live virus vaccine? ☐

Dates given mm dd yyyy mm dd yyyy
Dose1 ______/______/______ Dose2 ______/______/______

| 2. Immunity confirmed by blood titer? ☐ | Date Performed ______/______/______ |
|---|---|
| 3. Exemption? ☐ | Attach signed statement |

**HEPATITIS B:** Three doses of HB vaccine **OR** serologic evidence of immunity through a blood test

1. **THREE(3)** doses of Hepatitis B vaccine? ☐

Dates given: mm dd yyyy mm dd yyyy mm dd yyyy
Dose1 ______/______/______ Dose2 ______/______/______ Dose3 ______/______/______

| 2. Immunity confirmed by blood titer? ☐ | Date Performed ______/______/______ |
|---|---|
| 3. Exemption? ☐ | Attach signed statement |

**PART Ⅲ**：To be completed by the **visitor/observer**.

| | |
|---|---|
| 1. Have you ever had close contact with persons with known or active TB (tuberculosis) disease? | ☐Yes ☐No |
| 2. Were you born or have you lived or travelled for more than one month in one of the countries listed below? (if yes, circle the country name) | ☐Yes ☐No |

| | | | |
|---|---|---|---|
| Afghanistan | El Salvador | Mali | Senegal |
| Algeria | Equatorial Guinea | Marshall Islands | Serbia |
| Angola | Eritrea | Mauritania | Seychelles |
| Argentina | Estonia | Mauritius | Sierra Leone |
| Armenia | Ethiopia | Mexico | Singapore |
| Azerbaijan | Fiji | Micronesia | Solomon Islands |
| Bahrain | Gabon | Mongolia | Somalia |
| Bangladesh | Gambia | Morocco | South Africa |
| Belarus | Georgia | Mozambique | South Sudan |
| Belize | Ghana | Myanmar | Sri Lanka |
| Benin | Guatemala | Namibia | Sudan |
| Bhutan | Guinea | Nauru | Suriname |
| Bolivia (Plurinational State of) | Guinea-Bissau | Nepal | Swaziland |
| Bosnia and Herzegovina | Guyana | Nicaragua | Tajikistan |
| Botswana | Haiti | Niger | Thailand |
| Brazil | Honduras | Nigeria | Timor-Leste |
| Brunei Darussalam | India | Niue | Togo |
| Bulgaria | Indonesia | Pakistan | Trinidad and Tobago |
| Burkina Faso | Iran (Islamic Republic of) | Palau | Tunisia |
| Burundi | Iraq | Panama | Turkey |
| Cabo Verde | Kazakhstan | Papua New Guinea | Turkmenistan |
| Cambodia | Kenya | Paraguay | Tuvalu |
| Cameroon | Kiribati | Portugal | Uganda |
| Central African Republic | Kuwait | Peru | Ukraine |
| Chad | Kyrgyzstan | Philippines | Unit'd Rep of Tanzania |
| China | Lao Ppl's Democratic Rep | Poland | Uruguay |
| Colombia | Latvia | Portugal | Uzbekistan |
| Comoros | Lesotho | Qatar | Vanuatu |
| Congo | Liberia | Republic of Korea | Venezuela |
| Côte d'Ivoire | Libya | Republic of Moldova | Viet Nam |
| Dem Ppl's Rep of Korea | Lithuania | Romania | Yemen |
| Dem Rep of Congo | Madagascar | Russian Federation | Zambia |
| Djibouti | Malawi | Rwanda | Zimbabwe |
| Dominican Republic | Malaysia | Saint Vincent/Grenadines | |
| Ecuador | Maldives | Sao Tome and Principe | |

| | |
|---|---|
| 3. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? | ☐Yes ☐No |
| 4. Have you ever been a volunteer or health-care worker who served any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease –medically underserved, low-income, or abusing drugs or alcohol? | ☐Yes ☐No |

If you answered yes to any of these questions, please provide the following:

| | | |
|---|---|---|
| **Interferon-based Assay TB Blood Test (Quantiferon Gold Test or T-Spot)** | Date Performed<br>_____/_____/_____<br>mm dd yyyy | Result________________________ |

If the result of the above test is **POSITIVE**, you must provide the following:

| | | |
|---|---|---|
| **Chest X-ray** | Date Performed<br>_____/_____/_____<br>mm dd yyyy | Result________________________ |

**To the clinician: Please review and sign to verify that that information noted on this record is correct.**

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| Clinician name (MD/NP/PA) | Clinician Signature | Date |