



## 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.

Parts I, II, and III must be submitted with your application form.

Part IV must be submitted between 2 months and 1 month before your arrival in Japan.

Send to: [elective@jikei.ac.jp](mailto: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<br>of elective placement | _____ |                               |                                 |
| Dates of placement                           | _____ |                               |                                 |

Have you been exposed to a disease listed in the following website?

[https://www.mhlw.go.jp/english/wp/wp-hw4/dl/health\\_and\\_medical\\_services/P79.pdf](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.

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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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## Immunisation and Health Screening Form

### PART II To be completed and signed by a physician.

Tick appropriate box. ☒

#### MEASLES: 2 doses of measles vaccine or positive serology through a blood test

☐ Immunisation with 2 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 : \_\_\_\_\_ Date Performed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

#### MUMPS: 2 doses of mumps vaccine or serologic evidence of immunity through a blood test

1. Immunisation with 2 doses of live virus vaccine? ☐

Dates given mm/dd/yyyy

Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_

mm/dd/yyyy

Dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Immunity confirmed by blood titer? ☐

Inspection method and result

EIA ☐ Laboratory Result: \_\_\_\_\_ Date Performed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

#### RUBELLA: 2 doses of rubella vaccine or serologic evidence of immunity through a blood test

1. Immunisation with 2 doses of live virus vaccine? ☐

Dates given mm/dd/yyyy

Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

#### VARICELLA: 2 doses of varicella vaccine or serologic evidence of immunity through a blood test

1. Immunisation with 2 doses of live virus vaccine? ☐

Dates given mm/dd/yyyy

Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

#### HEPATITIS B: Serologic evidence of immunity through a blood test

Immunity confirmed by blood titer

(> 10 mIU/mL required) anti-HBs titer : \_\_\_\_\_

Date Performed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy



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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

\_\_\_\_\_  
Contact e-mail address



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#### PART IV

This final part must be sent to [elective@jikei.ac.jp](mailto:elective@jikei.ac.jp) **between 2 months and 1 month before your arrival** in Japan.

You must submit the results of either ① or ②.

If you fail to submit this form on time, your participation in the elective will be automatically cancelled.

First name \_\_\_\_\_ Surname \_\_\_\_\_

① Quantiferon Gold Test or T-Spot Test Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_  
mm dd yyyy

**\* Interferon-based Assay TB Blood Test (IGRA) within the last 12 months.**

② Chest X-ray Date performed : \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_  
mm dd yyyy

**\* A chest radiograph must be taken and examined for diagnosis within 2 months before your arrival date in Japan.**

Arrival date in Japan : \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

**Please review the information above and sign below.**

① Quantiferon Gold Test or T-Spot must be signed a physician at the student's institution,

② Chest X-ray must be signed by a clinician specializing in radiology, infectious diseases at the student's institution.

I hereby verify that the information provided on this form (Part IV) is accurate, to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name in block letters

\_\_\_\_\_  
Hospital/Institution name and address

\_\_\_\_\_  
Contact e-mail address

Please note if you have symptoms of possible infectious disease when starting your elective, your elective might be cancelled/terminated after consultation with a specialist.