



PERSONAL INFORMATION (please type)

Surname			
First and middle name(s)			
Home address		Date of birth (dd/mm/yyyy)	

IMMUNIZATION HISTORY

DISEASE	REQUIREMENTS	VACCINATION DOSES (date)	POSITIVE REACTIVE TITER	DISEASE HISTORY
MMR	Two doses of MMR are strongly recommended. Alternate regimen may also satisfy the requirement.	Dose 1 _____ Dose 2 _____	<input type="checkbox"/>	<input type="checkbox"/>
MEASLES	Two doses of vaccine OR blood test showing immunity OR history of disease	Dose 1 _____ Dose 2 _____	<input type="checkbox"/>	<input type="checkbox"/>
MUMPS	One dose of vaccine OR blood test showing immunity OR history of disease	Dose 1 _____	<input type="checkbox"/>	<input type="checkbox"/>
RUBELLA	One dose of vaccine OR blood test showing immunity. History of disease not accepted.	Dose 1 _____	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS B	Three doses (doses 1 and 2: given 4 weeks apart, and dose 3 at least 4-6 months after the dose 1). Series of dates and positive (>10ml/IU) serologic proof of immunity OR a blood test showing immunity. Acceptable blood test results: <ul style="list-style-type: none"> • Positive Hepatitis B Surface Antigen (Anti-HBsAg); • Positive Hepatitis B Core Antigen; • Positive Hepatitis B Surface Antigen. 	Dose 1 _____ Dose 2 _____ Dose 3 _____	<input type="checkbox"/>	<input type="checkbox"/>
VARICELLA	Two doses of vaccine (given at least 1 month apart) OR one dose, if given before the age of 13, OR positive immune titer OR history of disease	Dose 1 _____ Dose 2 _____	<input type="checkbox"/>	<input type="checkbox"/>
TETANUS-DIPHTHERIA	One dose of vaccine administered within the last 10 years.	Dose 1 _____	<input type="checkbox"/>	<input type="checkbox"/>
POLIO	Completed primary series of polio immunizations.	Date completed _____ Oral Polio Vaccine (OPV) _____ Enhanced Inactivated Polio Vaccine (E-IPV) _____	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS	Student must have received a PPD test within 12 months of the requested elective date, irrespective of prior vaccination with BCG. A student with positive reaction must forward the results of the evaluation, including results of a chest X-ray and subsequent management to the Faculty of Medicine.			

ADDITIONAL IMMUNIZATIONS (RECOMMENDED)

DISEASE	COMMENTS	VACCINATION DOSES (date)
MENINGOCOCCAL	Students are recommended to receive the vaccine to protect themselves against several of the more common strains of the meningococcal infections. The vaccine protects against most strains of the bacteria causing meningitis, which is an inflammation of the covering of the brain and spinal cord, fatality rate of which is 10-15%. Although the disease is rare, students living in dormitories and individuals with weak immune systems can be more susceptible to the disease. Immunization requires one injection in the arm, and is 85-90% protective against strains A, C, Y and W-135, but not type B. Most meningococcal diseases in Poland are caused by type B.	Dose _____
INFLUENZA	Annual vaccination is recommended.	Dose _____
PNEUMOCOCCAL	Students with removed spleens or suffering from chronic illnesses (e.g. diabetes mellitus) receive the vaccine.	Dose _____

NOTE: Should you contract a communicable disease during enrollment, you are required to notify this office and your course coordinator/attending immediately, and remove yourself from patient care activity.

VERIFICATION

Surname and name of the healthcare provider	Place and date	Stamp
Full address and telephone number	Signature	