Juntendo University Hospital Immunization Requirements

Name: _____

Date of Birth: _____

Measles:	2 doses after first birthday • Dose #1 & 2 must be 30 days apart Dose #1 Date: ___ . ___ . ___ (Day . Month . Year) Dose #2 Date: ___ . ___ . ___ (Day . Month . Year)	or	Titer report, only if proof of vaccination not available • Above 800 mIU/ml or 16.0 EIA Date: ___ . ___ . ___ (Day . Month . Year) Result: ___ ☐ = mIU/ml ☐ = EIA
Mumps:	2 doses after first birthday • Dose #1 & 2 must be 30 days apart Dose #1 Date: ___ . ___ . ___ (Day . Month . Year) Dose #2 Date: ___ . ___ . ___ (Day . Month . Year)	or	Titer report, only if proof of vaccination not available • Above 200 mIU/ml or 4.0 EIA Date: ___ . ___ . ___ (Day . Month . Year) Result: ___ ☐ = mIU/ml ☐ = EIA
Rubella:	2 doses after first birthday • Dose #1 & 2 must be 30 days apart Dose #1 Date: ___ . ___ . ___ (Day . Month . Year) Dose #2 Date: ___ . ___ . ___ (Day . Month . Year)	or	Titer report, only if proof of vaccination not available • Above 400 mIU/ml or 8.0 EIA Date: ___ . ___ . ___ (Day . Month . Year) Result: ___ ☐ = mIU/ml ☐ = EIA
Varicella:	2 doses after first birthday • Dose #1 & 2 must be 30 days apart Dose #1 Date: ___ . ___ . ___ (Day . Month . Year) Dose #2 Date: ___ . ___ . ___ (Day . Month . Year)	or	Titer report, only if proof of vaccination not available • Above 200 mIU/ml or 4.0 EIA Date: ___ . ___ . ___ (Day . Month . Year) Result: ___ ☐ = mIU/ml ☐ = EIA
Hepatitis B:	3 doses • Dose #1 • Dose #2: 1 month after Dose #1 • Dose #3: 5 months after Dose #2 Dose #1 Date: ___ . ___ . ___ (Day . Month . Year) Dose #2 Date: ___ . ___ . ___ (Day . Month . Year) Dose #3 Date: ___ . ___ . ___ (Day . Month . Year)	&	HBsAb Titer Report • Above 10 mIU/ml or 0.2 EIA Date: ___ . ___ . ___ (Day . Month . Year) Result: ___ ☐ = mIU/ml ☐ = EIA
Tuberculosis:	PPD (Mantoux) • Within 1 year of the program. • An induration ≥ 10mm requires an x-ray report Date: ___ . ___ . ___ (Day . Month . Year) Result: ___ mm induration or IGRA Blood Test • Within 1 year of the program. • A positive result requires a x-ray report Date: ___ . ___ . ___ (Day . Month . Year) Result: ☐ = Positive ☐ = Negative	or	X-Ray Report • Within 1 year of the program. Date: ___ . ___ . ___ (Day . Month . Year) Result: ☐ = No Signs of Tuberculosis ☐ = Other comments attached
Influenza:	Vaccine • Required if attending Juntendo University Hospital between: October 1 - April 30 Vaccine Date: ___ . ___ . ___ (Day . Month . Year)		
COVID-19:	Vaccine Name: Dose #1 Date: ___ . ___ . ___ (Day . Month . Year) Dose #2 Date: ___ . ___ . ___ (Day . Month . Year) Dose #3 Date: ___ . ___ . ___ (Day . Month . Year)		

Healthcare Provider:

Organizational Stamp:

Name: _____

Signature: _____

Date: _____

Address: _____

Phone: _____