Juntendo University Hospital Immunization Requirements

Name: _____ Date of Birth: _____

Measles, Mumps, Rubella (M.M.R.):	2 doses of the M.M.R. vaccine after first birthday • Dose #1 & 2 must be 30 days apart				
	Dose #1 Date: ___ . ___ . ___ (Day . Month . Year)	Dose #2 Date: ___ . ___ . ___ (Day . Month . Year)			
Measles (Rubeola):	2 doses of the measles vaccine after first birthday • Dose #1 & 2 must be 30 days apart		or	Titer report, if proof of vaccination not available • Above 800 mIU/ml or 16.0 EIA	
	Dose #1 Date: ___ . ___ . ___ (Day . Month . Year)	Dose #2 Date: ___ . ___ . ___ (Day . Month . Year)		Test Date: ___ . ___ . ___ (Day . Month . Year)	Result: ___ ☐ = mIU/ml ☐ = EIA
Mumps:	2 doses of the mumps vaccine after first birthday • Dose #1 & 2 must be 30 days apart		or	Titer report, if proof of vaccination not available • Above 200 mIU/ml or 4.0 EIA	
	Dose #1 Date: ___ . ___ . ___ (Day . Month . Year)	Dose #2 Date: ___ . ___ . ___ (Day . Month . Year)		Date: ___ . ___ . ___ (Day . Month . Year)	Result: ___ ☐ = mIU/ml ☐ = EIA
Rubella:	2 doses of the rubella vaccine after first birthday • Dose #1 & 2 must be 30 days apart		or	Titer report, if proof of vaccination not available • Above 400 mIU/ml or 8.0 EIA	
	Dose #1 Date: ___ . ___ . ___ (Day . Month . Year)	Dose #2 Date: ___ . ___ . ___ (Day . Month . Year)		Date: ___ . ___ . ___ (Day . Month . Year)	Result: ___ ☐ = mIU/ml ☐ = EIA
Varicella:	2 doses after first birthday • Dose #1 & 2 must be 30 days apart		or	Titer report, only if proof of vaccination not available • Above 200 mIU/ml or 4.0 EIA	
	Dose #1 Date: ___ . ___ . ___ (Day . Month . Year)	Dose #2 Date: ___ . ___ . ___ (Day . Month . Year)		Date: ___ . ___ . ___ (Day . Month . Year)	Result: ___ ☐ = mIU/ml ☐ = EIA
Hepatitis B:	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		or	X-Ray Report • Within 1 year of the program.	
	Date: ___ . ___ . ___ (Day . Month . Year)	Result: ___ mm induration		Date: ___ . ___ . ___ (Day . Month . Year)	Result: ☐ = No Signs of Tuberculosis ☐ = Other comments attached
	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			
Influenza:	Influenza Vaccine • Required if attending between November 1 – April 30. • Vaccination must be administered on or after September 1 of the applicable influenza season.				
	Vaccine Date: ___ . ___ . ___ (Day . Month . Year)				

Healthcare Provider: Organizational Stamp:

Name: _____

Signature: _____

Date: _____

Address: _____

Phone: _____