Immunization record for ERASMUS and Exchange Students

This form must be fully completed, legible, and signed by a qualified physician. Please ensure that any attached documentation is in English, signed, dated and stamped with the official clinic/ laboratory stamp. Incomplete forms may result in your application being rejected.

| Family Name: | |
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| First Name: | |
| Gender: () male () female | () diverse |
| Date of Birth: | |
| Hepatitis B Students must be immune to Hepatit | tis B, either as a result of vaccination or following natural infection. |
| Vaccinations: Date of 1. vaccination: Date of 2. vaccination: Date of 3. vaccination: If necessary, date of booster vaccinat | ion: |
| Date and result of Hepatitis B surfac | e antibody (Anti HBs IgG) blood test: |
| Date and result of Hepatitis B core a | ntibody (Anti HBc IgG) blood test: |
| Hepatitis C Date and result of Hepatitis C antibo | dy blood test, taken within the last 3 months: |
| Measles, Mumps, Rubella | |
| Positive Measles, Mumps and Rubella | a antibody (IgG) blood test: |
| OR | |
| two MMR vaccinations: 1 | |
| Varicella (Chickenpox) | |
| Positive varicella antibody (IgG) blood | I test: |
| OR | |
| two Varicella vaccinations: 1. | |

A copy of the blood test results and a copy of the vaccination card must be enclosed with the translation in German or English.

| Tuberculosis skin test (PPD Merieux) or TB INF gamma release Assay (IGRA Test), taken within the <u>last 12 months</u> : |
|--|
| Date and result (mm induration) of PPD Merieux: |
| OR Date and result of IGRA Test: |
| if positive (more than 6 mm induration) or reactive IGRA Test => X-Ray of the lung: |
| date and result of the X-Ray: |
| It is recommended to be informed about one's own HIV-status (the status does not have to be revealed). |
| All students must be vaccinated against <u>tetanus</u> , <u>diphtheria</u> , <u>pertussis and poliomyelitis</u> within the <u>last 10 years</u> and should bring the immunization record about it. |
| Name of the vaccine and date of last vaccination: |
| |
| Name and address of physician: |
| Official stamp: |
| Signature of physician: |
| Date: |
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Please release this form to the Occupational health care provider "Betriebsärztlicher Dienst" via <u>the upload portal</u>.