# STUDENT IMMUNISATION FORM

for studies at CHARLES UNIVERSITY
Third Faculty of Medicine

Student's surname and name: Date of Birth

**Please note:** This form MUST be completed and signed by a Physician and present with a copy of your health insurance on the date of registration for medical study at the Third Faculty of Medicine. **You will not be registered unless this form is complete**.

| REQUIRED | Date – Primary Series | Date – Boosters |
|---|---|---|
| **1. Tetanus** | | |
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| | | |

Tetanus: Booster doses should have been received within the last l0 years.

**3. MEASLES**
**Titre: _________________________** or Immunization ___________________________________

**4. HEPATITIS B:**
**Titre:** Date____________________**or**
**Vaccine**: Date 1)_______________Date 2)_______________Date 3)________________

N.B. Medical students must provide proof of positive Hepatitis B antibody status.

**5. TUBERCULOSIS :**
**TB Skin Test**: Positive □ Negative □ Date of test: _________________________

If your TB test results will be outdated, please keep a copy of this form. You must resubmit the updated test results/chest x-ray report before you will be permitted to register at the Third Faculty of Medicine

**TB Skin Test**: Positive □ Negative □ Date of test: _________________________

If the results are positive because of BCG vaccine or any other causes, an official report of a chest x-ray taken less than 6 months prior to starting your studies at the Third Faculty of Medicine

Chest x-ray report taken within past 6 month attached: **Yes** □ **No** □

I certify that the immunization date given above is accurate and that this student‘s immunization status is thus up-to-date.

___________________________ ________________________________________

Physician‘s Surname Address and Phone Number

Date: ______________________

___________________________
Physician‘s Signature