Facultad de Medicina

**INMUNIZATION FORM**

Before starting the internship, it is the responsibility of each student to check that she/he has had the recommended vaccines for measles, mumps, rubella, diphtheria, tetanus, whooping cough, poliomyelitis, hepatitis B, chickenpox, and meningitis and has carried out the tuberculin skin test. At the time of starting the internship, each student must be in possession of documentation that demonstrates the appropriate vaccinations have been received and tests been done.

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| MUMPS, MEASLES, RUBELLA (MMR)  It is necessary to demonstrate a positive serological test result (attach copy of the report). The antecedent of having had the illness is not valid. | Positive titer MUMPS:  \_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  Positive titer MEASLES:  \_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  Positive titer RUBELLA:  \_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ |
| Please, if possible, indicate the dates of vaccinations, but note that this does not override the requirement to attach copies of serological test results. | Date MMR#1: \_\_\_/\_\_\_/\_\_\_  Date MMR#2: \_\_\_/\_\_\_/\_\_\_  Measles #1 Date: \_\_\_/\_\_\_/\_\_\_  Measles #2 Date: \_\_\_/\_\_\_/\_\_\_  Rubella Date: \_\_\_/\_\_\_/\_\_\_  Mumps Date: \_\_\_/\_\_\_/\_\_\_ |
| TETANUS, DIPHTHERIA, WHOOPING COUGH. | Tetanus Diphtheria (booster)  Date: \_\_\_/\_\_\_/\_\_\_  Tetanus only  Date: \_\_\_/\_\_\_/\_\_\_  Diphtheria only  Date: \_\_\_/\_\_\_/\_\_\_  Tetanus, diphtheria and whooping cough  Date: \_\_\_/\_\_\_/\_\_\_ |
| HEPATITIS B | Dates de administration:  #1 \_\_\_/\_\_\_/\_\_\_  #2 \_\_\_/\_\_\_/\_\_\_ #3 \_\_\_/\_\_\_/\_\_\_  Antibody titer:\_\_\_\_\_\_  Date: \_\_\_/\_\_\_/\_\_\_  Results:  ( )POSITIVE (Antibodies present)  ( )NEGATIVE (Antibodies not present) |
| TUBERCULIN SKIN TEST  (After January 2010. Proceed to ----)  It is not necessary to do this test if:   1. You received the BCG vaccine during childhood. Date: \_\_\_/\_\_\_/\_\_\_ 2. If a test done before the year 2010 is compatible with latent TB.   Type and date:  \_\_\_/\_\_\_/\_\_\_  #mm of induration: \_\_\_\_  It is necessary to present the report of chest x-ray and the date when was done:  \_\_\_/\_\_\_/\_\_\_  Antibiotic treatments undertaken (if any) and their dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Type:  Date: \_\_\_/\_\_\_/\_\_\_  #mm of induration: \_\_\_\_\_\_  ( ) NEGATIVE  ( ) Compatible with latent TB latent  If compatible with latent TB, it is necessary to present the report of chest x-ray and the date when was done: \_\_\_/\_\_\_/\_\_\_  Antibiotic treatments undertaken (if any) and their dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| VARICELLA (CHICKENPOX)  Positivity in serological tests or documentation demonstrating that the vaccine has been administered. | Positive varicella titer:  Date:  \_\_\_/\_\_\_/\_\_\_  Vaccine #1 Date: \_\_\_/\_\_\_/\_\_\_ Vaccine #2 Date: \_\_\_/\_\_\_/\_\_\_ |
| MENINGITIS | Type: ( ) Polysaccharide serogroup. A and C  Type: ( ) Polysaccharide serogroup. A,C, Y and W135  Type: ( ) Conjugate serogroup C  Date: \_\_\_/\_\_\_/ |
| POLIO (optional) | Salk: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_  Sabin: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ |

Date: \_\_\_/\_\_\_/\_\_\_

Signature of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stamp