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:_____________________________

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: a) You received the BCG vaccine during childhood. Date: ___/___/___ b) 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