ASAN Medical Center

88, Olympic-ro 43-gil, Songpa-gu, Seoul 05505, Korea

Immunization Form (Mandatory)

Please fill this form and submit to Department of Nursing via e-mail (ksjeong@amc.seoul.kr).

Full Legal Name		
Last Name	First Name	Middle Name

Nationality	**Date of Birth (Month/Day/Year)**	**Gender**
		❑Male ❑Female

Required immunizations: Please record the date of immunizations or blood tests. Please print clearly.

A. Measles–Mumps–Rubella (MMR)

: Proof of positive titers **OR** Two doses of each individual component (within 10 years).

Positive Titers :

Measles: _____ /_____ /_____ (Month Day Year)

Mumps: _____ /_____ /_____ (Month Day Year)

Rubella: _____ /_____ /_____ (Month Day Year)

OR

Measles Vaccination:

#1: _____ /_____ /_____ (Month Day Year)

#2: _____ /_____ /_____ (Month Day Year)

Mumps Vaccination:

#1: _____ /_____ /_____ (Month Day Year)

#2: _____ /_____ /_____ (Month Day Year)

Rubella Vaccination:

#1: _____ /_____ /_____ (Month Day Year)

#2: _____ /_____ /_____ (Month Day Year)

B. Tetanus-Diphtheria-Pertussis (Tdap)

: Must be within the past 10 years. Must be Tdap. No other form of the Tetanus shot is acceptable.

Tdap Vaccination: _____ /_____ /_____ (Month Day Year)

C. Varicella (Chickenpox)

: Proof of a positive titer **If the result is negative,** Two doses required (within 5 years).

Varicella Positive Titer: _____ /_____ /_____ (Month Day Year)

if result is negative

Varicella Vaccination #1: _____ /_____ /_____ (Month Day Year)

Varicella Vaccination #2: _____ /_____ /_____ (Month Day Year)
4-8 weeks apart from #1

D. Hepatitis B

: Proof of a positive titer **If the result is negative,** Completed 3 part series required.

Hepatitis B Positive Titer: _____ /_____ /_____ (Month Day Year)

Hepatitis B Carrier: Yes / No

if result is negative

Hepatitis B Vaccination #1:

_____ /_____ /_____ (Month Day Year)

Hepatitis B Vaccination #2:
at least 1 month* after #1

_____ /_____ /_____ (Month Day Year)

Hepatitis B Vaccination #3:
at least 2 months* after #2
at least 4 months* after #1

_____ /_____ /_____ (Month Day Year)

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E. Hepatitis A

: Proof of a positive titer. **If the result is negative,** Completed 2 part series required.

Hepatitis A Positive Titer: _____ /_____ /_____
Month Day Year

if result is negative

Hepatitis A Vaccination #1: _____ /_____ /_____
Month Day Year

6 months apart from one another

Hepatitis A Vaccination #2: _____ /_____ /_____
Month Day Year

F. Tuberculosis

: The results of Tuberculin Skin Test (TST) **OR** IGRA test required.

Induration size: _____mm

Date read: _____ /_____ /_____
Month Day Year

Diagnosis at time of reading: ❑ Positive ❑ Negative

OR

IGRA Date: _____ /_____ /_____
Month Day Year

Result : ❑ Positive ❑ Negative

G. Influenza

: If visiting Asan Medical Center on December ~ May. Must be most recently developed vaccination. Vaccination must be done at least 14 days prior to arrival date.

Influenza Vaccination Date: _____ /_____ /_____
Month Day Year

Health Care Provider OR Medical Records Official		
Last Name	First Name	Middle Name
Address		Telephone number (including area/country code)

Signature of Health Care Provider OR Medical Records Official	**Date**