



Seoul National University Health Form

Name (please print): _____
Last First Middle
Date of Birth : ____/____/____ Nationality : _____
Email : _____ Telephone : _____

Seoul National University requires all students to be immunized against certain communicable diseases. To comply have this form completed and signed by your health care provider and submitted to the above address as soon as possible and no later than the due date.

1. Immunizations

Required*	Dates Given (Month/Day/Year)	Requirements
Measles-Mumps-Rubella (MMR) If administered separately or positive titers obtained, record below	#1 ____/____/____ #2 ____/____/____ month day year month day year	Two doses at age ≥ 12 months, at least 28 days apart. History of disease is not acceptable.
Measles (Rubeola)	Date #1 ____/____/____ #2 ____/____/____ OR Positive titer _____ Date: ____/____/____	Two doses or positive titer
Mump	Date #1 ____/____/____ #2 ____/____/____ OR Positive titer _____ Date: ____/____/____	Two doses or positive titer
Rubella (German Measles)	Date #1 ____/____/____ #2 ____/____/____ OR Positive titer _____ Date: ____/____/____	Two doses or positive titer

* Required vaccinations should be given prior to arrival.

** Recommended vaccinations are available at the SNU Health Service Center or off-campus clinics at own expense after arrival.

2. Tuberculosis Screening

IGRA (interferon-gamma release assay) **OR** chest X-ray must be done **within six months** prior to your SNU admittance.

IGRA Type: ☐ QuantiFERON (QFT-GIT) ☐ T-SPOT Date: ____/____/____ Result: ☐ Negative ☐ Positive
If IGRA results are positive, a chest X-ray is REQUIRED.

OR

Chest X-ray Date ____/____/____ Result: ☐ Normal ☐ Abnormal \rightarrow Finding: _____
Please attach the chest X-ray report in English.

If IGRA is/was positive or chest X-ray is positive, did student complete a course of antibiotic therapy?

- ☐ YES _____
Drug, Dose, Frequency, Duration and Dates
- ☐ NO _____
Please document reason prophylaxis or treatment not done

PROVIDER INFORMATION REQUIRED

Physician's Name (please print) _____ Signature _____ License No _____ Date(M/D/Y) _____
Clinic/Institution: _____
Address: _____
Phone number: _____ Fax number: _____

Stamp of hospital/clinic