Seoul National University Health Form

Name (please print): _____ _____ _____
Last First Middle

Date of Birth : ____/____/_____ Nationality : _____

Student ID: _____ 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

PPD test OR chest X-ray (CXR) must be done within six months prior to your official dormitory move-in date.
SNU Gwanak Residence Halls accepts either PPD or Chest X-ray as valid tests for tuberculosis screening.
Only one of the two tests needs to be initially performed.

PPD: Date placed ___/___/___**Date read** ____/____/_____**# of mm induration**** Result: ☐ Negative ☐ Positive

** If PPD results are 10mm or more, a chest X-ray is REQUIRED.

OR

Chest X-ray Date____/_____/_____ Result: ☐ Normal ☐ Abnormal → Finding:_____
Please attach the chest X-ray report in English.

If PPD 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