Immunization Requirements for Visiting Medical Students

Full Name: _____ Country: _____ Passport number: _____ Date of Birth: _____

Immunization	Dose 1 –Date	Dose 2 – Date	Dose 3 – Date	Signature
IPV/OPV				
Tdap				
MMR				
Engerix–Hep B				
(chickenpox) Varicella				
Covid-19				

Please perform one of the following:

- **Quantiferon**: _____
- **Mantoux:**

  Reading follow –date: _____ result: _____mm

  Reading follow –date: _____ result: _____mm

*__Remark__: for positive results above 10 mm, the student requires to provide x-ray and documentation of treatment

Confirmation by a physician/Certified Nurse

I hereby confirm that the above student received all the above obligatory immunization.

Name: _____ Title: _____ Signature: _____

Position: _____

Name and address of clinic: _____

Clinic official stamp

_____

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