Please keep a copy of this form for your records

Toyo Eiwa University

To be completed by student.

Student's Full Legal Name (exactly as printed on your passport or other government-issued photo identification)		
Last/Family/Surname(s)	First/Given name(s)	Middle name(s)

Date of Birth example 1998/JAN/25		
yyyy	mmm	dd

Certificate of Immunization

To be completed and signed by physician.

If a student does not have antibodies against the infectious diseases listed below, we strongly recommend that she get vaccinated.

Required immunization Please record the date of immunizations, boosters or tests. Please print clearly.

Measles-Mumps- Rubella (MMR): Two immunization on or after the first birthday, at least 1 month apart.

First MMR yyyy/mmm/dd / /
Second MMR yyyy/mmm/dd / /

If administered separately, record below,		
Measles (Rubeola) Two immunizations as described above	1st / /	2nd / /
Rubella (German Measles) Two immunizations as described above	1st / /	2nd / /
Mumps (Epidemic parotitis) Two immunizations as described above	1st / /	2nd / /

Exemption from MMR injection:

☐ A positive serological test (titer) for immunity to any of the above disease is acceptable instead of immunization (a history of the disease is not acceptable)

Date performed: Positive MEASLES titer : (/ /)
Positive RUBELLA titer : (/ /)
Positive MUMPS titer : (/ /)

Varicella (chickenpox): Two immunizations on or after the first birthday, at least 1 month apart.	1st / /	2nd / /

Exemption from Varicella injection:

☐ A positive serological test (titer) for immunity to Varicella or a certified history of the disease is acceptable instead of immunizations

Dates performed: Positive VARICELLA titer : (/ /)
or Age at infection : (years old)
or Date of disease : (/ /)

Continued on reverse side

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I certify that this immunization information was transferred from the above-named student's individual medical records.	☐YES ☐NO
I certify that this student has received all immunizations required by law.	☐YES ☐NO
Do you consider the student to be in adequate immunological health for full and successful participation in the study abroad program?	☐YES ☐NO
If "NO", please describe the reason.	

Licensed physician		
Last/Family/Surname(s)	First/Given name(s)	Middle name(s)

Address	Telephone number (including area/county code)

Required Signature	Date
	yyyy mmm dd / /