



# ASAN Medical Center

88, Olympic-ro 43-gil, Songpa-gu, Seoul 05505, Korea  
http://eng.amc.seoul.kr

## Immunization Form (Mandatory)

Please fill this form and submit to Asan Medical International via e-mail (intedu@amc.seoul.kr).

Full Legal Name		
Last Name	First Name	Middle Name
Nationality	Date of Birth (Month/Day/Year)	Gender
		<input type="checkbox"/> Male <input type="checkbox"/> Female

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

A. Measles–Mumps–Rubella (MMR)		
: Proof of positive titers <b>OR</b> Two doses of each individual component (within 10 years).		
Positive Titers :		
Measles: _____ / _____ / _____ Month    Day    Year	Mumps: _____ / _____ / _____ Month    Day    Year	Rubella: _____ / _____ / _____ Month    Day    Year
<b>OR</b>		
Measles Vaccination:	Mumps Vaccination:	Rubella Vaccination:
#1: _____ / _____ / _____ Month    Day    Year	#1: _____ / _____ / _____ Month    Day    Year	#1: _____ / _____ / _____ Month    Day    Year
#2: _____ / _____ / _____ Month    Day    Year	#2: _____ / _____ / _____ 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 <b>If the result is negative</b> , Two doses required (within 5 years).	
Varicella Positive Titer: _____ / _____ / _____ Month    Day    Year	
<b>if result is negative</b>	
Varicella Vaccination #1: _____ / _____ / _____ Month    Day    Year	Varicella Vaccination #2: _____ / _____ / _____ 4-8 weeks apart from #1    Month    Day    Year

D. Hepatitis B		
: Proof of a positive titer <b>If the result is negative</b> , Completed 3 part series required.		
Hepatitis B Positive Titer: _____ / _____ / _____ Month    Day    Year	Hepatitis B Carrier: Yes / No	
<b>if result is negative</b>		
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

**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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Hepatitis A Vaccination #2: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year      6 months apart from one another      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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Result :  Positive  
Month Day Year       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**

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