Nursing Student's Physical Requirements

Name:

Date of birth:

❍ Please fill out your vaccination information below and obtain a signature from a university official.

Category	Proof of vaccinations	Or Positive titer
Measles	Date Dose 1: Date Dose 2:	Date:
Mumps	Date Dose 1: Date Dose 2:	Date:
Rubella	Date Dose 1: Date Dose 2:	Date:
Varicella	Date Dose 1: Date Dose 2:	Date:
	Have a history of chickenpox Diagnosis date:	
Hepatitis B	Date Dose 1: Date Dose 2: Date Dose 3:	Date:
Tuberculosis	Chest X-ray examination (within the last 3 months) Result (test date): ※ If there are abnormal findings, practice is possible after ruling out active tuberculosis.	
I have confirmed the vaccination as above and hereby certify it. Date: Title: Name: (signature)		