**Health Assessment Form**

Please complete a table below giving dates of vaccine OR dates of antibody test, method and result. Please be asked to attach copies of relevant test results. The signature of a physician must be included in this documentation.

Your Name:

Your Institute:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item** | **Date of vaccine given** | **Date of Test** | **Method**  **(eg.EIA, PA, ELISA)** | **Result**  **(value)** |
| **Measles** | Dose1 ……../………/……….  Date Month Year  Dose2 ……../………/……….  Date Month Year |  |  |  |
| **Rubella** | Dose1 ……../………/……….  Date Month Year  Dose2 ……../………/……….  Date Month Year |  |  |  |
| **Varicella** | Dose1 ……../………/……….  Date Month Year  Dose2 ……../………/……….  Date Month Year |  |  |  |
| **Mumps** | Dose1 ……../………/……….  Date Month Year  Dose2 ……../………/……….  Date Month Year |  |  |  |
| **Hepatitis B**  **(Anti HBs)** | Dose1 ……../………/……….  Date Month Year  Dose2 ……../………/……….  Date Month Year  Dose3 ……../………/……….  Date Month Year |  |  |  |
| **COVID-19** | Dose1 ……../………/……….  Date Month Year  Dose2 ……../………/……….  Date Month Year  Dose3 ……../………/……….  Date Month Year  Dose4 ……../………/……….  Date Month Year |  |  |  |
| **Item** | **Date of Test** | **Result** | | |
| **Chest X-ray**  **Requirement** | ……../………/……….  Date Month Year | 🗆 Revealed no abnormalities  🗆 Other Comments: | | |

I hereby acknowledge that this document and any source of information provided in this document are an accurate representation of this person’s current immunization status.

Institution:

Print Name of Physician:

Signature of Physician: Date:

Date / Month / Year

*Remarks: The information provided in this form will be kept strictly confidential and only used to aid professional response in the case of student illness or emergency; and/or for the prevention of such illness or emergency.*