KAIST Health Form

Name : _____ _____ _____
Last First Middle

Date of Birth(Y/M/D) : _____/_____/_____ Nationality : _____
yyyy mm dd

Email : _____ Telephone : _____

KAIST requires all students to be immunized against certain communicable diseases.
To comply have this form completed and signed by your health care provider and submitted to the email as soon as possible and no later than the due date.

1. Immunizations

Required*	Dates Given (YYYY/MM/DD)	Requirements
[Option 1] **Measles-Mumps-Rubella (MMR) Vaccination**	**#1** _____/____/_____ **#2** _____/_____/____ yyyy mm dd yyyy mm dd	**2 doses of MMR or positive titer** 2 doses at age ≥ 12 months, at least 28 days apart. History of disease is **not** acceptable **If the antibody titer does not indicate immunity, an injection series is required.**
OR		
[Option 2] **LAB Report Confirming Immunity** **Measles:** Date _____/_____/_____ (***Attach Lab Report In English)*** **Mumps:** Date _____/_____/_____ (***Attach Lab Report In English)*** **Rubella:** Date _____/_____/_____ (***Attach Lab Report In English)***		
Recommended**	**Dates Given (YYYY/MM/DD)**	**Recommends**
Varicella	Date #1 _____/____/____ #2 _____/____/____	2 doses at age ≥ 12 months, at least 28 days apart.
Tetanus/Diphtheria/Pertussis	Date: _____/____/_____	1 dose within the past 10 years
Hepatitis B	#1 _____/____/_____ #2 ____/____/_____ #3 _____/____/_____	Dose #1, any age Dose #2, 1-2 months after dose #1 Dose #3, 6 months after dose #1
Hepatitis A	#1 _____/____/_____ #2 ____/____/_____	Dose #2, 6 months after dose #1
Meningococcal	Date: _____/____/_____	
Has report of positive (reactive) immune titer **MUST SUBMIT COPY OF LAB REPORT**		

* Required vaccinations should be given prior to arrival.
** Recommended vaccinations are available at the KAIST Clinic or off-campus clinics at own expense.

2. Tuberculosis Screening

IGRA (interferon-gamma release assay) **OR** chest X-ray must be done **within three months** prior to your KAIST admittance.

IGRA Type: ☐ QuantiFERON (QFT-GIT) ☐ T-SPOT Date*(yyyy/mm/dd)*: _____/____/_____ Result: ☐ Negative ☐ Positive
If IGRA results are positive, a chest X-ray is REQUIRED.

OR

Chest X-ray Date _____/_____/_____ Result: ☐ Normal ☐ Abnormal → Finding:_____
yyyy mm dd
Please attach the chest X-ray report in English.

If IGRA is/was positive or chest X-ray is positive, did student complete a course of antibiotic therapy?

☐ YES _____
Drug, Dose, Frequency, Duration and Dates

☐ NO _____
Please document reason prophylaxis or treatment not done

PROVIDER INFORMATION REQUIRED

_____ _____ _____ _____
Physician's Name Signature License No Date(yyyy/mm/dd)

Clinic/Institution:_____

Address:_____

Phone number:_____ Fax number:_____

Official Stamp of hospital/clinic