



IMMUNISATION & IMMUNE STATUS RECORD

For Visiting Students Requesting an IFMSA Exchange in Greece

Please ask your doctor, or Occupational Physician, to complete the following details about your health. Your doctor must sign the statement at the bottom of the page.

SURNAME (Please Print): _____ FIRST NAME: _____			
DATE OF BIRTH: _____ <i>Day/Month/Year</i>			
TETANUS & DIPHTHERIA	Date of last Booster Dose: _____ <i>Day/Month/Year</i>		Other Booster _____ <i>Day/Month/Year</i>
POLIO VACCINE	Date of last Booster Dose: _____ <i>Day/Month/Year</i>		Other Booster _____ <i>Day/Month/Year</i>
WHOOPING COUGH <small>(For paediatrics department)</small>	Date of last Booster Dose: _____ <i>Day/Month/Year</i>		Other Booster _____ <i>Day/Month/Year</i>
INDIVIDUALS BORN BEFORE 1970 MAY BE CONSIDERED IMMUNE TO MEASLES AND MUMPS			
	Immune:	Immune by Serology	Immune by Vaccination
MEASLES <small>(Red Measles / Rubeola)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ <i>Day/Month/Year</i>	1. Day _____ Month _____ Year _____ 2. Day _____ Month _____ Year _____
MUMPS	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ <i>Day/Month/Year</i>	1. Day _____ Month _____ Year _____ 2. Day _____ Month _____ Year _____
RUBELLA <small>(German Measles)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ <i>Day/Month/Year</i>	1. Day _____ Month _____ Year _____ 2. Day _____ Month _____ Year _____
CHICKENPOX <small>(Varicella)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ <i>Day/Month/Year</i>	1. Day _____ Month _____ Year _____ 2. Day _____ Month _____ Year _____
MENINGITIDOCOCCUS TYPE C <small>(Meningitis C)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No		1. Day _____ Month _____ Year _____ <small>(MUST BE DONE WITHIN THE LAST 2 YEARS)</small>
HEPATITS A	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ <i>Day/Month/Year</i>	1. Day _____ Month _____ Year _____ 2. Day _____ Month _____ Year _____
HEPATITIS B	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ <i>Day/Month/Year</i>	1. Day _____ Month _____ Year _____ 2. Day _____ Month _____ Year _____ 3. Day _____ Month _____ Year _____ 4. Day _____ Month _____ Year _____
HEP B Surface Antibody Levels:	_____		5. Day _____ Month _____ Year _____ 6. Day _____ Month _____ Year _____
TUBERCULOSIS			
BCG VACCINE	<input type="checkbox"/> Yes <input type="checkbox"/> No	BCG Scar Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	
TUBERCULIN SKIN TEST (MANTOUX)	2 STEP TUBERCULIN SCREEN TEST (TST)	Step 1 Day _____ Month _____ Year _____ Result: _____mm.	Step 2 Day _____ Month _____ Year _____ Result: _____mm.
	MOST RECENT TST Other than Baseline 2-Step	Day _____ Month _____ Year _____ Result: _____mm.	
CHEST X-RAY	<input type="checkbox"/> Yes <input type="checkbox"/> No	Day _____ Month _____ Year _____ Result _____	
Any Serious Medical Conditions			

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Do you have or have you had any of the following?	NO	YES	Details and dates (on back sheet if necessary)
Epilepsy, recurrent fits, faints, blackouts or dizzy spells?			
Diabetes?			
Any allergies?			
Hepatitis or jaundice?			
Carrier state for MRSA?			
Back/neck or shoulder pain lasting more than two weeks, or on more than three occasions?			
Problems with your hands, arms, legs or feet which affect movement or use?			
Skin trouble including eczema or dermatitis?			
Heart problems or high blood pressure?			
Recurrent bronchitis or shortness of breath?			
Asthma, hay fever or any other allergic condition, including sensitivity to antibiotics?			
Hearing problems, ear infections or discharging ears?			
Any defect of eyesight (which cannot be corrected by glasses or contact lenses, including color blindness)?			
Do you have frequent diarrhoea or other bowel disorder?			
Gastric or duodenal ulcer or frequent and prolonged indigestion?			
Dysentery, Typhoid, Gastroenteritis, Food Poisoning?			
Colostomy or ileostomy?			
Blood Disorders e.g. Haemophilia, Sickle Cell Anaemia?			
During the past 12 months any unexplained: <ul style="list-style-type: none"> ➤ weight loss ➤ fever ➤ night sweats ➤ or cough for more than three weeks? 			
Have you been to hospital for any tests, treatment or operations during the past three years?			
Have you seen your GP (General Practitioner) during the past six months?			
Are you waiting for any hospital appointments/treatment?			
Have you been restricted from any particular type of work or had to give up a job/course for medical reasons?			
Are you taking medication of any kind (injections, pills, tablets or medicines from a doctor) at the moment?			
Nervous or mental illness including anxiety, depression, eating disorder or other psychological problem?			
Counselling, psychotherapy or psychiatric treatment?			
Dependence on alcohol, prescription, non prescription drugs or other substances?			
Do you consider yourself to have a disability/special need (physical or psychological)?			
If the answer to the above question is YES			
Does your condition affect normal day to day activities e.g. cooking, dressing?			
Does your condition affect your ability to carry out any of the duties associated with the course for which you have applied?			
Any other health problems not mentioned above?			
Any other condition requiring hospital treatment or investigation?			
For conditions requiring hospital investigation or treatment, please indicate name of hospital, specialist and hospital reference number if known.			

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A. PERSONAL DETAILS

TITLE: Mr / Mrs / Miss / Dr / Other (Please circle)

LAST NAME:

MAIDEN NAME:

FIRST NAME(S):

SEX: MALE FEMALE DATE OF BIRTH:

ADDRESS:

.....

HOME TELEPHONE NUMBER:

CONTACT TELEPHONE NUMBER:

MOBILE NUMBER

E-MAIL ADDRESS:

PLEASE NOTE: It is **your** responsibility to take, and follow specialist advice if you are or you believe you may be infected with any blood borne virus including Human Immunodeficiency Virus (HIV).

**THE CONTENTS OF THIS FORM ARE HELD IN STRICT CONFIDENCE BY
THE OCCUPATIONAL HEALTH DEPARTMENT.**

YOU ARE REMINDED THAT IF YOU KNOWINGLY MAKE A FALSE STATEMENT OR CONCEAL ANY INFORMATION REGARDING YOUR MEDICAL HISTORY, YOU WILL BE LIABLE TO HAVE YOUR EXCHANGE TERMINATED.

DECLARATION

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief.

Doctor's Signature:

Date:

Print Name:

Practice Address:

Telephone Number:

Practice Stamp

PLEASE NOTE: Insufficient information will require further enquiries and will delay the application.

SEND TO: Dimitris Karanikas, **e-mail:** neo@helmsic.gr (scanned) or **fax:** 0030 2310999179
ALSO the students **MUST** have it and show it (the original) upon arrival.