Immunization record for ERAMUS+

This form must be fully completed, legible, and signed by a qualified physician. Please ensure that any attached documentation is in English, signed, dated and stamped with the official clinic/ laboratory stamp. Incomplete forms may result in your application being rejected.

Family Name:

First Name:

Date of Birth:

Hepatitis B
Students **must be immune** to Hepatitis B, either as a result of vaccination or following natural infection.

Vaccinations:
Date of 1. vaccination:
Date of 2. vaccination:
Date of 3. vaccination
Date of booster vaccination:

Date and result of **Hepatitis B surface antibody** blood test:

Date and result of **Hepatitis B core antibody** blood test:

Hepatitis C
Date and result of **Hepatitis C antibody** blood test:

Measles, Mumps, Rubella

Positive Measles, Mumps and Rubella antibody blood test:

OR

two MMR vaccinations: 1.
2.

Varicella (Chickenpox)

Positive varicella antibody blood test:

OR

two Varicella vaccinations: 1.
2.

A copy of the blood test results and a copy of the vaccination card must be enclosed.

Tuberculosis skin test (PPD Merieux) or TB INF gamma release Assay (IGRA Test), taken within in last 12 months:

Date and result (mm induration) of PPD Merieux:
OR Date and result of IGRA Test**:**

if positive (more than 6 mm induration) or reactive IGRA Test => X-Ray of the lung:

date and result of the X-Ray**:**

It is recommended to be informed about one's own HIV-status (the status does not have to be revealed).

All students must be vaccinated against tetanus, diphtheria, pertussis and poliomyelitis within the last 10 years and should bring the immunization record about it.

Name of the vaccine and date of last vaccination:

_____

All students must provide proof of complete vaccination protection against the SARS-CoV-2 coronavirus.
The vaccine type must be authorized in Germany, listed by the Paul Ehrlich Institute
(https://www.pei.de/EN/newsroom/dossier/coronavirus/coronavirus-content.html?cms_pos=3)

Name of vaccine and date of 1st vaccination:
Name of vaccine and date of 2nd vaccination:
Name of vaccine and date of 3rd vaccination:

In case of a recovered person with evidence of recovery, at least two doses of vaccine are required.

Date of positive PCR Test (Proof of recovery):

_____

Name and address of physician:

Official stamp:

Signature of physician:

Date:

Please release this form to the Occupational health care provider "Betriebsärztlicher Dienst" either via mail or e-mail no later than the respective deadlines. Any documents that arrives later, will not be considered.

Mail address:
Betriebsärztlicher Dienst
Moorenstr. 5
40225 Düsseldorf
Germany

E-mail:
betriebsarzt@med.uni-duesseldorf.de