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**VACCINATION RECORD**

***To be completed by a licensed physician who is not related to applicant***

Students applying to the University of Zagreb School of Medicine, Medical Studies in English, are required to fully complete mandatory immunization and provide the information with details of vaccination. Adequate vaccination against Morbilli – Mumps - Rubella (MMR), Polio (OPV, IPV), Tetanus- Diphtheria - Pertussis (TDP, TDaP) and Hepatitis B is required. Manotoux test (TB) or Quantiferon TB-test date and result not older than 6 months is obligatory.

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F**

**Address, City, Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IMMUNIZATION STATUS**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Vaccine*** | ***Dates of given doses*** | | | | | | |
| DTP |  |  |  |  |  |  |  |
| DT (TdaP) |  |  |  |  |  |  |  |
| Polio (OPV, IPV) |  |  |  |  |  |  |  |
| MMR |  |  |  |  |  |  |  |
| Hep B |  |  |  |  |  |  |  |
| HiB |  |  |  |  |  |  |  |
| BCG |  |  |  |  |  |  |  |
| Mantoux test (results in mm) |  |  |  |  |  |  |  |
| Quantiferon-TB test (positive/negative) |  |  |  |  |  |  |  |
| Additional notes on immune status record: |  |  |  |  |  |  |  |
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**Place, country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH CARE INSTITUTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHYSICIAN'S PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STAMP OF THE HEALTH CARE INSTITUTION:**