

Immunization for Health Care Workers at the Kepler Universitätsklinikum

We ask you to complete this questionnaire as soon as possible and send it to **Arbeitsmedizin** with a **copy of your vaccination record or digital certificates**.

name:	social security number (SSN) / date of birth	
	planned activity:	
adress:	department:	
	course / vintage:	
mobile phone:	training site:	
private email:	Date from:	Date to:

Mandatory vaccinations	date of immunization	vaccination recommended	
Measles – Mumps - Rubella (two dose vaccine required)	1. Immunization	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	2. Immunization	Yes <input type="checkbox"/>	No <input type="checkbox"/>
No two dose vaccination, serological testing is required	Immunity to Measles:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Immunity to Mumps:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Immunity to Rubella:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Varicella	History of disease - Date:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Immunity to varicella:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
No history of disease, serological testing neg	1. Immunization varicella	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	2. Immunization varicella	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Hepatitis B (at least 3 dose vaccination) Name of vaccine:	1. Immunization	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	2. Immunization		
	3. Immunization		
	Booster Injection:	Next due vaccination:	
	Serological testing:		

Recommended vaccinations	Last date of immunization	vaccination recommended	
Hepatitis A (for High-risk group kitchen mandatory) At least vaccinated once Name of vaccine:	1. Immunization 2. Immunization	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pertussis		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Poliomyelitis		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diphtherie		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tetanus		Yes <input type="checkbox"/>	No <input type="checkbox"/>

Medical confirmation:	
I hereby confirm sufficient immunity against	
<input type="checkbox"/> Measles/Mumps/Rubella	<input type="checkbox"/> Varicella and
<input type="checkbox"/> Hepatitis B	
I hereby confirm the accuracy of the information on the vaccination records from:	
Name:, SSN and Date of Birth.:	
Date:	Signature and stamp of the physician: