

Immunization Requirements

for students and guests in the clinical area with patient contact

Family name(s):	First name(s):
Date of birth (dd.mm.yyyy):	Austrian social security number (if available):
Student ID number (if available):	Application Procedure number (if available):

Compulsory vaccinations:

	Vaccination date		Titer, Date	Sufficient Immunity
Measles	1st vaccination:	or	Titer:	<input type="checkbox"/> yes
	2nd vaccination:		Date:	<input type="checkbox"/> no
Mumps	1st vaccination:	or	Titer:	<input type="checkbox"/> yes
	2nd vaccination:		Date:	<input type="checkbox"/> no
Rubella	1st vaccination:	or	Titer:	<input type="checkbox"/> yes
	2nd vaccination:		Date:	<input type="checkbox"/> no
Varicella	1st vaccination:	or	Titer:	<input type="checkbox"/> yes
	2nd vaccination:		Date:	<input type="checkbox"/> no
Hepatitis B	1st vaccination:	and	Titer: Date: Protection until:	
	2nd vaccination:			
	3rd vaccination:			
	Last booster vaccination:			

The immunity to measles, mumps, rubella and varicella can be proven either by two vaccinations **or** a positive titer. If you had a varicella infection, a positive titer is also necessary.

The protection against Hepatitis B must be proven by a complete basic immunization (3 vaccinations) **and** a current sufficient titer. If necessary, a booster vaccination is required.

Confirmation by a general practitioner/board certified doctor:	
I, the attending physician, confirm with my signature that the requirements for working in the clinical area with patient contact are fulfilled (sufficient immunity against measles, mumps, rubella, varicella and sufficient protection against hepatitis B).	
_____	_____
Date	Stamp and signature of a physician

Compulsory information on voluntary vaccinations:

It is mandatory to provide the information, even if the vaccinations are not mandatory for your stay. Voluntary vaccinations should be updated according to your national vaccination recommendations.

	Vaccinated	Vaccination date	Booster recommended
Pertussis*	<input type="checkbox"/> yes <input type="checkbox"/> no	Date of last vaccination:	<input type="checkbox"/> yes <input type="checkbox"/> no
Poliomyelitis*	<input type="checkbox"/> yes <input type="checkbox"/> no	Date of last vaccination:	<input type="checkbox"/> yes <input type="checkbox"/> no
Diphtheria*	<input type="checkbox"/> yes <input type="checkbox"/> no	Date of last vaccination:	<input type="checkbox"/> yes <input type="checkbox"/> no
Tetanus*	<input type="checkbox"/> yes <input type="checkbox"/> no	Date of last vaccination:	<input type="checkbox"/> yes <input type="checkbox"/> no
Hepatitis A**	<input type="checkbox"/> yes <input type="checkbox"/> no	Date of last vaccination:	<input type="checkbox"/> yes <input type="checkbox"/> no

* For pertussis, poliomyelitis, diphtheria and tetanus a refresher every 5 years is strongly recommended!

** For Hepatitis A recommendation is two doses of a Hepatitis A vaccine (e.g. Havrix 1440, Avaxim, Epaxal) or three doses of a HepA/B combination (e.g. Twinrix).

Confirmation by a general practitioner/board certified doctor:	
I hereby confirm that the information on the voluntary vaccinations is correct.	
_____	_____
Date	Stamp and signature of a physician

Declaration of the student:

By signing this document

I understand that I may not be permitted to perform the tasks of my stay (including coursework) at Med Uni Graz on the clinical premises of Steiermärkische Krankenanstaltengesellschaft m.b.H. (KAGes) hospitals if the proof of compulsory immunization as indicated above is missing/insufficient. This procedure follows the guideline 2000.0100 of the KAGes.

I agree that my personal data regarding the proof of immunization will be stored and processed by the Medical University of Graz as long as necessary for the purpose of monitoring compliance with KAGes guideline 2000.0100. This confirmation can be withdrawn at any time.

I acknowledge that the Medical University of Graz assumes no liability whatsoever for any delays in study and research time as well as damage to health or other damages, that I or third parties may suffer as a result of failing to fulfil the immunization requirements or by obtaining the vaccinations. I will fully indemnify and hold harmless the Medical University of Graz against any claims of third parties arising herefrom.

Date

Signature