University of Ljubljana
Faculty of Medicine

Erasmus+

IMMUNIZATION HISTORY FORM

Name and surname: _____ **Date of Birth:** _____

Sending institution (University):_____

Telephone Numbers: Home: _____ **Mobile:** _____

Required Immunizations:

Immunization	**Date**	**Immune Titer** (Attach results)
1) Tetanus/Diphtheria/Pertussis (Tdap)	#1___/___/___(provide history of immunization)	N/A
2) Tetanus toxoid (Td)	#1___/___/___ (provide history of immunization)	N/A
3) MMR	#1___/___/___ #2___/___/___	N/A
4) Measles	#1___/___/___ #2___/___/___	___/___/____
5) Hepatitis B	#1___/___/___ #2___/___/___ #3___/___/___	
provide anti HBs titer		___/___/___
6) Varicella (chicken pox)	provide IgG anti VZV	___/___/___
- If immune titer is negative, do provide history of vaccination	#1___/___/___ #2___/___/___	
7) Tuberculin Skin Test (PPD) or QuantiFERON TB test	Date Placed: ___/___/___	Date Read: ___/___/___

- If tuberculin test is positive, then do provide chest x-ray results (Attach copy of radiology report):

Date: ___/___/___ Results: _____

8) Provide a proof of MRSA - negative smear test

Date: ___/___/___ Results: _____

9) COVID-19 VACCINATION #1___/___/___ #2___/___/___

Verification of Information:
Signature / Seal of Health Care Provider: _____

Clinic or Health Office Name: _____

Address: _____ City: _____ Country: _____ Post code: _____

Telephone: _____ Fax: _____

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