



# Seoul National University BK Residence Halls

## Health Certificate

Name (please print): \_\_\_\_\_  
Last First Middle  
Date of Birth : \_\_\_\_/\_\_\_\_/\_\_\_\_ Nationality : \_\_\_\_\_  
Email : \_\_\_\_\_ Telephone : \_\_\_\_\_

Seoul National University requires all residents to be immunized against certain communicable diseases. To comply, have this form completed, signed and sealed with an official seal of the institution by your health care provider. **Only the original copy of this form will be valid.**

### 1. Immunizations

Required	Dates Given (Month/Day/Year)	Requirements
<b>Measles-Mumps-Rubella (MMR)</b> If administered separately or positive titers obtained, record below	#1 ____/____/____ month day year      #2 ____/____/____ month day year	Two doses at age $\geq$ 12 months, at least 28 days apart. History of disease is not acceptable
Measles (Rubeola)	Date #1 ____/____/____    #2 ____/____/____ OR Positive titer _____    Date: ____/____/____	Two doses or positive titer

※ Only residents with their 2nd dose of MMR or Measles vaccination will be admitted to the BK Residence Halls.

### 2. Tuberculosis Screening

PPD or chest X-ray (CXR) must be done **within six months** prior to your official move-in date.

History of BCG vaccination does not prevent Tuberculosis screening.

SNU BK Residence Halls accepts either PPD or Chest X-ray as valid tests for tuberculosis screening.

Only one of the two tests needs to be initially performed.

**Chest X-ray:** Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Result:  Normal  Abnormal → Finding: \_\_\_\_\_

If the Chest x-ray is found to be Abnormal, a PPD test is REQUIRED.

*Please attach chest X-ray report in English*

**PPD:** Date placed \_\_\_\_/\_\_\_\_/\_\_\_\_ Date read \_\_\_\_/\_\_\_\_/\_\_\_\_ # of mm induration \_\_\_\_\_  Negative  Positive

If PPD results are 10mm or more, a chest X-ray is REQUIRED.

If both PPD test is/was positive and CXR is abnormal, did student complete a course of antibiotic therapy?

YES \_\_\_\_\_  
Drug, Dose, Frequency, Duration and Dates

Please attach a document of a follow up tuberculosis screening completed after the antibiotic therapy that shows either a negative PPD or normal CXR result.

### PROVIDER INFORMATION REQUIRED

Signature of health care provider \_\_\_\_\_ Physician/Medical provider Name (please print) \_\_\_\_\_ Date \_\_\_\_\_

Clinic/Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

**Official Seal of the Institution:**

