

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 and digital COVID certificates**.

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

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 2. Immunization 3. Immunization Booster Injection: Serological testing:	Yes <input type="checkbox"/> No <input type="checkbox"/> Next due vaccination:
Hepatitis A For kitchen and pediatrics At least vaccinated once Name of vaccine:	1. Immunization 2. Immunization	Yes <input type="checkbox"/> No <input type="checkbox"/>

Recommended vaccinations	Last date of immunization	vaccination recommended
Covid-19 Name of vaccine:	Validity vaccination certificate / digital COVID certificates until _____ Vaccination <input type="checkbox"/> recovered <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Next due vaccination:
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 <input type="checkbox"/> Hepatitis A (high risk group kitchen and pediatrics)
I hereby confirm the accuracy of the information on the voluntary vaccination records from Name:, SSN and Date of Birth.: Date: Signature and stamp of the physician: