

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**.

name:	social security number / 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	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
Covid-19 Name Impfstoff:	1. Impfung 2. Impfung	Ja <input type="checkbox"/> Nein <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"/>
Hepatitis A Name of vaccine:	1. Immunization 2. Immunization	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 und <input type="checkbox"/> Hepatitis B.	
I hereby confirm the accuracy of the information on the voluntary vaccination records.	
Date:	Signature and stamp of the physician: