IMMUNIZATION SCHEDULE, PROPHYLAXIS AND HEALTH RECORD

STUDENT MOBILITY CENTER

KMC MANIPAL

S.NO: _____ DATE:_____

PHOTO

NAME: _____

AGE: _____ SEX: _____DATE OF BIRTH: _____MARITAL STATUS: _____

BLOOD GROUP:_____ HEIGHT:_____ WEIGHT:_____

PHONE NO:_____ MOBILE NO:_____

EMAIL ID:_____INSTITUTIONAL EMAIL ID:_____

EMERGENCY CONTACT NO:_____EMAIL ID:_____

STATUS:FACULTY ☐ STUDENT-UNDER GRADUATE☐ POST GRADUATE ☐

COUNTRY OF ORIGIN:_____

COUNTRY OF CITIZEN SHIP: _____

PASSPORT NO: _____

LAST TRAVEL DESTINATION: _____ PORT: _____

DATE OF DEPARTURE: _____ DATE OF ARRIVAL IN INDIA: _____

MEDICAL INSURANCE NAME:_____POLICY NUMBER:_____

COVERAGE:_____

PERIOD OF VISIT AT MAHE, MANIPAL	OPTION 1:FROM: TO: OPTION 2:FROM: TO: OPTION 3:FROM: TO:
DEPARTMENTS INTENDING TO VISIT	
1.	3.
2.	4.
FIELD VISITS PLANNED(kindly state location, period and purpose)	
1.	
2.	
3.	

IMMUNIZATION RECORD

(kindly fill the form below and attach copies of official records)

DISEASE	VACCINE	DATE OF VACCINES	ANTIBODY TITRES	DATE OF DOCUMENT RECORD	TYPE OF DOCUMENT RECORD	LEVEL OF IMPORTANCE
Hepatitis A						recommended
Measles Mumps Rubella						mandatory
Varicella Zoster						recommended
Adult Tetanus Diphtheria						mandatory
Influenza						recommended
Japanese Encephalitis						recommended
Cholera						recommended

Rabies						recommended
Hepatitis B						Mandatory
Meningitis						recommended
Typhoid						recommended
Yellow Fever						recommended
BCG						
COVID-19						Recommended(Subject to change)

Note:

As per WHO the following vaccines are recommended for travelling to India

Mandatory for all
Hepatitis B
MMR
TD

If staying for more than a month
Varicella Vaccine
Japanese encephalitis (only if you are planning extensive rural activities)

Mandatory if arriving from certain countries
OPV (Afghanistan, Ethiopia, Israel, Kenya, Nigeria, Pakistan, and Somalia)
Yellow Fever (Africa and South America)

For self – protection (optional)
Typhoid
Hepatitis A

PROPHYLAXIS RECORD (kindly fill the form below and attach copies of legal prescriptions)					
Disease	Drug	Dosage And Frequency	Date Of First Dose	Date Of Last Dose	Prescription From
Malaria					

DECLARATION

I _____, aged _____years, hailing from _____

Here by state that the above stated information is official and correct to the best of my knowledge. And I here by state not to hold any party responsible for the lack of evidence due to any deficiency in the above stated record.

I understand the purpose of this document and agree that the student mobility centre may obtain screening and immunization details as required to assist in my assessment of fitness for the course/s.

U understand that failure to disclose information may be detrimental to my health and could affect my student status and lead to termination of the enrolment. I give my consent tot eh student mobility Centre to advise the departments and/or institutions where it relates to or impacts on my fitness to practice/ observe/participate.

I hereby agree to disclose to the student mobility centre and the University of any Further Changes in health status after the submission of this document.

Please sign below when you have read, understood, and accepted the declaration.

Signature: _____ Date:_____

Name: _____

Advising physicians sign and seal: _____ Date :_____

Reference: wwwnc.cdc.gov/travel , nathnac.net