



Seoul National University Gwanak Residence Halls

Health Certificate

Name (please print): _____
Last First Middle
Date of Birth : ____/____/____ Nationality : _____
Student ID Number : _____
Email : _____ Telephone : _____

Seoul National University requires all students 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
Measles-Mumps-Rubella (MMR) If administered separately or positive titers obtained, record below	#1 ____/____/____ month day year #2 ____/____/____ month day year	Two doses at age ≥ 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 Gwanak Residence Halls.

2. Tuberculosis Screening

PPD or chest X-ray (CXR) must be done **within six months** prior to your official dormitory move-in date.
History of BCG vaccination does not prevent Tuberculosis screening.
SNU Gwanak 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:

