



# KASTURBA MEDICAL COLLEGE

MANGALORE

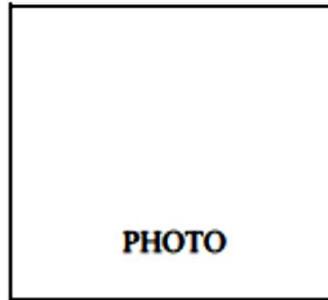
(A constituent unit of MAHE, Manipal)

## IMMUNIZATION SCHEDULE, PROPHYLAXIS AND HEALTH RECORD

STUDENT MOBILITY CENTER, KMC MANGALORE

S.NO: \_\_\_\_\_

DATE: \_\_\_\_\_



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: \_\_\_\_\_



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<b>PERIOD OF VISIT AT KMC, MANGALORE</b>	OPTION 1:FROM: TO:
	OPTION 2:FROM: TO:
	OPTION 3:FROM: TO:
<b>DEPARTMENTS INTENDING TO VISIT</b>	
1.	3.
2.	4.
<b>FIELD VISITS PLANNED(kindly state location, period and purpose)</b>	
1.	
2.	
3.	

<b>IMMUNIZATION RECORD</b> (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



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

**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



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## 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					



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## 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.

I 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 to the 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 MAHE 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](http://wwwnc.cdc.gov/travel), [nathnac.net](http://nathnac.net)