



U.S. Department of State
VACCINATION DOCUMENTATION WORKSHEET
 For Use with DS-2053 or DS-2054 To Be Completed by Panel Physician Only

CMB No. 1405-0113
 EXPIRATION DATE: 06/30/2014
 ESTIMATED BURDEN: 30 minutes /Set
 Page 2 of 2

Name (Last, First, MI)					Exam Date (mm-dd-yyyy)		REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS NOT REQUIRED FOR REFUGEE APPLICANTS				
Birth Date (mm-dd-yyyy)			Passport Number		Alien (Case) Number					NOTE FOR PANEL PHYSICIANS: For refugee applicants, please complete only if reliable vaccination documents are available.	
1. Immunization Record										Blanket Waiver(s) To Be Requested if Vaccination Not Medically Appropriate, Check Suitable Box(es) Below	
Vaccine History Transferred From a Written Record (List Chronologically from Left to Right)					Vaccine Given by Panel Physician (mm-dd-yyyy)	Completed Series (/ of Completed) Write "VH" if Vaccines History, or write Date of Lab Test if Immune	Not Age Appropriate	Insufficient Time Interval	Contra-indicated	Not Routinely Available	Not Fall (Flu) Season
Vaccine	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)							
Specify (check) vaccine: <input type="checkbox"/> DT <input type="checkbox"/> DTP <input type="checkbox"/> DTaP											
Specify (check) vaccine: <input type="checkbox"/> Td <input type="checkbox"/> Tdap											
Specify (check) vaccine: <input type="checkbox"/> Botul (CIV) <input type="checkbox"/> IPV											
Specify (check) vaccine: <input type="checkbox"/> MMR (Measles-Mumps-Rubella) <input type="checkbox"/> Rubella											
Specify (check) vaccine: <input type="checkbox"/> Measles <input type="checkbox"/> Measles - Rubella											
Specify (check) vaccine: <input type="checkbox"/> Mumps <input type="checkbox"/> Mumps - Rubella											
Rotavirus											
Hib											
Hepatitis A											
Meningococcal											
Pneumococcal											
Influenza											
2. Results											
<input type="checkbox"/> Vaccine History Incomplete											
<input type="checkbox"/> Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate (as indicated)											
<input type="checkbox"/> Applicant will request an individual waiver based on religious or moral convictions.											
<input type="checkbox"/> Vaccine history complete for each vaccine, all requirements met (Documented Above).											
<input type="checkbox"/> Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.											

MMR (measles, mumps, rubella) immunity is required. Two doses of MMR vaccine is one way to demonstrate immunity.

Meningococcal vaccine is not required. It is optional. However, you must complete a form stating whether, or not you have had this vaccine at age 16 or older.

Give Copy to Applicant



U.S. Department of State
VACCINATION DOCUMENTATION WORKSHEET
 To Be Completed by Panel Physician Only
 For US Vaccination Requirements

OMB No. 1405-0113
 EXPIRATION DATE: 09/30/2017
 ESTIMATED BURDEN: 30 minutes
 (See Page 2 of 2)

GIVE COPY TO APPLICANT

Name (Last, First, MI)	Birth Date (mm-dd-yyyy)	Exam Date (mm-dd-yyyy)	Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate.
Passport Number	Alien (Case) Number		

1. Immunization Record					Vaccine Given By Panel Site	For Designated Refugees Only: Additional Vaccine Given by IOM*	Test for Immunity	Indicate reason below. Mark all that apply (see legend): A, B, C, D, F, H
Vaccine History Transferred From a Written Record List Chronologically from Left to Right. Provide date as mm-dd-yyyy								
Vaccine	Date	Date	Date	Date	Date	Date	Date	Date
Diphtheria, tetanus, pertussis								
<input type="checkbox"/> DT, DTP, DTaP								
<input type="checkbox"/> Td								
<input type="checkbox"/> Tdap								
Polio								
<input type="checkbox"/> OPV								
<input type="checkbox"/> IPV								
Measles, mumps, rubella								
<input type="checkbox"/> MMR								
<input type="checkbox"/> Measles								
<input type="checkbox"/> Mumps								
<input type="checkbox"/> Rubella								
Rotavirus								
<input type="checkbox"/> RotaTeq (RV5)								
<input type="checkbox"/> Rotarix (RV1)								
Hib								
Hepatitis A								
Hepatitis B								
Meningococcal								
<input type="checkbox"/> MCV4								
<input type="checkbox"/> Other MCV conjugate								
Varicella								
<input type="checkbox"/> Vaccine								
<input type="checkbox"/> Varicella History								
Pneumococcal								
<input type="checkbox"/> PCV 7								
<input type="checkbox"/> PCV 10								
<input type="checkbox"/> PCV 13								
<input type="checkbox"/> PPSV 23								
Influenza								
Other								

MMR (measles, mumps, rubella) immunity is required. Two doses of MMR vaccine is one way to demonstrate immunity.

Meningococcal vaccine is not required. It is optional. However, you must complete a form stating whether, or not you have had this vaccine at age 16 or older.

2. Summary for Immigrant Visa Applicants	<input type="checkbox"/> US vaccination requirements COMPLETE (Requesting a Blanket Waiver)	US vaccination requirements NOT Complete:
		<input type="checkbox"/> Requesting Individual Waiver based on religious or moral convictions <input type="checkbox"/> Requesting Adoptee Exemption <input type="checkbox"/> Applicant refuses vaccinations

3. Panel Physician Name (printed)	Panel Physician signature	Date (mm-dd-yyyy)
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I attest I performed this examination and have an agreement with the Department of State or supervised completion of this form. I am the same Panel Physician that signs the DS 2054.

* Only for designated refugees in special IOM vaccination program

Blanket waiver legend: A Not age appropriate B Insufficient time interval to complete series C Contraindicated D Not routinely available F Not flu season H Known chronic hepatitis B virus infection

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4. Contraindication to vaccination

If a vaccination was contraindicated, mark which contraindication were present (*mark all that apply*)

- Pregnant
- Immune compromised
- History of severe allergic reaction to vaccine or vaccine component
- Other severe reaction to vaccine
- Current moderate to severe illness
- Other, specify: _____

5. Remarks

6. Panel Physician Initials

Date (*mm-dd-yyyy*)

PAPERWORK REDUCTION ACT STATEMENT

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: PRA_BurdenComments@state.gov

CONFIDENTIALITY STATEMENT

AUTHORITIES The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of State and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may, in the discretion of the Secretary of State, be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.

PURPOSE The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws. More information on the Routine Uses for this collection can be found in the System of Records Notice State-24, Medical Records.

IMMUNIZATION CERTIFICATE

◆Please type or print◆

Name: _____
 Birth Date: _____
 Address: _____ Japan

	Month/Day/Year	Month/Day/Year	Month/Day/Year	Month/Day/Year
DTP 三種混合	12/28/1992	02/10/1993	03/23/1993	05/25/1994
POLIO 小児麻痺	11/27/1992	05/07/1993	06/19/2015	(scheduled) 07/17/2015
TETANUS 破傷風 (Within 10 years)	07/03/2015	/	/	/
DIPHTHERIA シフテリア (Within 10 years)	07/03/2015	/	/	/
MEASLES (Rubeola) はしか (Immunization with LIVE VACCINE or documentation of Measles antibody titer)	Antibody titer (:) Date:	Immunized 02/08/1994	Immunized 06/17/2008	/
RUBELLA (German Measles) 風疹 (Immunization with LIVE VACCINE or documentation of Rubella antibody titer)	Antibody titer (:) Date:	Immunized 10/30/1995	/	/
MUMPS おたふくかぜ (Immunization with LIVE VACCINE or documentation of Mumps antibody titer)	Antibody titer (:) Date:	Immunized 12/13/1996	/	/
VARICELLA 水痘 (Immunization with LIVE VACCINE or documentation of Varicella antibody titer)	Antibody titer (:) Date:	Immunized 06/06/1995	/	/
BCG	07/09/1993	/	/	/
TUBERCULIN SKIN TEST ツベルクリン (Within 6 months)	Date: 06/17/2015 Normal: Yes / <input checked="" type="radio"/> No	Result 14 mm	/	/
CHEST X-RAY 胸部レントゲン	Date: 06/19/2015 Normal: <input checked="" type="radio"/> Yes / No	/	/	/
HEPITIS B B型肝炎	1st 06/19/2015	2nd (scheduled) 07/17/2015	3rd (scheduled) 12/04/2015	/
MENINGITIS 髄膜炎	06/26/2015	/	/	/
OTHERS HPV	02/04/2011	03/04/2011	09/02/2011	/

MMR (Measles, Mumps, Rubella) immunity is required. One dose of live Rubella vaccine, one dose of live Mumps vaccine, and two doses of live measles vaccine is one way to demonstrate immunity.

I certify that this student has received the immunization listed above on the date (s) indicated.

Physician's Signature: _____ Date: _____
 Physician's Name: _____
 Hospital Name: _____ Phone: _____
 Address: _____

HIBIYA CLINIC
 Toho Twin Tower BLDG B25
 1-3-2, YURAKUCHO, CHITOSE
 TOKYO, 100-0006, JAPAN

INFORMATION FOR PHYSICIANS

1. The dates of vaccination on each certificate to be recorded in the following sequence : day, month, year, the month in letters. Example: January 1, 1998 is written 1 January 1981.
2. If vaccination is contraindicated on medical grounds, the physician should provide the traveller with a written opinion, which health authorities should take into account.
3. Vaccination certificate requirements of countries are published by WHO in *International travel and health - vaccination requirements and health advice*. The list of designated yellow-fever vaccinating centres for international travel. This information is usually also available from local health offices.
4. Please be sure to always consider that your patient may have a travel-associated illness.

RENSEIGNEMENTS DESTINÉS AUX MÉDECINS

1. La date de la vaccination doit être portée sur les certificats dans l'ordre suivant : jour, mois, année, le mois étant indiqué en toute lettres. Exemple 1er janvier 1981.
2. Si la vaccination est contre indiquée pour raison médicale, le médecin doit fournir au voyageur une attestation indiquant son opinion, dont l'autorité sanitaire aux frontières pourra tenir compte.
3. Les exigences des pays en matière de vaccination sont publiées par l'OMS dans la brochure *voyages internationaux et conseils d'hygiène à l'intention des voyageurs*. La liste des centres habilités à pratiquer la vaccination contre la fièvre jaune pour les voyages internationaux. En général, les autorités sanitaires locales possèdent ces renseignements.
4. Tenez toujours compte du fait que votre patient peut être atteint d'une maladie liée à un voyage.

DMP : FGZ Trading ouaga tél : 30 - 08 - 46

COMMUNE DE OUAGADOUGOU
 Direction de l'Action Sanitaire
 WORLD HEALTH ORGANIZATION
 ORGANISATION MONDIALE DE LA SANTE
 Service Habilité



INTERNATIONAL CERTIFICATE
 OF VACCINATION
 CERTIFICAT INTERNATIONAL
 DE VACCINATION
 BURKINA FASO

INTERNATIONAL HEALTH REGULATIONS
 RÈGLEMENT SANITAIRE INTERNATIONAL

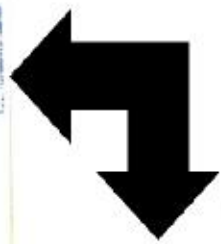
Issued to
 Délivré à
 Passport
 or
 Travel Document
 Numéro du
 ou
 de la pièce

Most students coming from African countries have this vaccination booklet. It also comes in other pastel colors.

COMMUNE DE OUAGADOUGOU
 Direction de l'Action Sanitaire
 Service de Vaccination et de
 Justification
 Service Habilité

OTHER VACCINATIONS - AUTRES VACCINATIONS

Date	physician's signature Signature du médecin	Dose	Nature of vaccine Genre de vaccin
09 AOU 2013	Mme Sow Setrou I.D.E		VACCIN ANTI MENINGO COCCIQUE A-CYW 105 Lot N° H514A
09 AOU 2013	Mme Sow Setrou I.D.E	0,5ml R0A 65200-5	
09 AOU 2013	Mme Sow Setrou I.D.E	0,5ml Tetanos 67088	



Most students coming from African countries also have the meningitis vaccine demonstrated by a stamp inside of the booklet.