ALMA MATER STUDIORUM – UNIVERSITÀ DI
BOLOGNA SCUOLA DI MEDICINA E CHIRURGIA

IMMUNISATION AND HEALTH REQUIREMENTS – A.Y. 2025/26

The form on the following page is a mandatory requirement for all incoming exchange students who apply for clinical rotations; it must be **completed, signed and sealed by a registered physician** according to the student's medical records and/or reports.

Instructions for the PHYSICIAN

Please fill out the form IN CAPITAL LETTERS and tick the relevant boxes according to the medical certificates and/or records produced by the student.

Instructions for the STUDENT

The signed and sealed form, together with all the required attachments, must be uploaded on the indicated platform as per instructions received by the Erasmus Office.

After a **positive assessment (idoneità)** by the Occupational Medicine service, you will be cleared to attend clinical rotations.

All the above information will be notified on your institutional mailbox (name.surname@studio.unibo.it), so it is advisable that you check it on a regular basis.

Students who fail to bring their certificates concerning immunisation and health requirements or who do not receive a positive assessment by the Occupational Medicine service will NOT be allowed to attend clinical rotations.

The medical data submitted with the "Immunisation and Health Requirements" form are confidential and will be used by the Occupational Medicine service of Alma Mater Studiorum – Università di Bologna (U.O. Medicina del Lavoro – Pavillion 9, 1st floor, S.Orsola-Malpighi hospital) for the purpose of checking that you are fit to attend medical training activities in healthcare settings, in compliance with Italian regulation including data Regulation (EU) 2016/679 (General Data Protection Regulation).

PLEASE DO NOT EMAIL THIS FORM

*This form and all required attachments **must be completed before your arrival and presented** at the Occupational Medicine after your arrival according to instructions.*
*Students who fail to bring their medical certificates or who do not receive a positive assessment by the Occupational Medicine service **will not be allowed to attend clinical rotations.***

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IMMUNISATION AND HEALTH REQUIREMENTS – A.Y.25/26

STUDENT PERSONAL INFORMATION (please write IN CAPITAL LETTERS)

Forename(s):	*Surname(s):*	*Sex:* ❑ M ❑ F
Date of Birth: *(dd/mm/yyyy)*	*Place and Country of Birth:*	
Sending Institution:		*Erasmus code:*

PHYSICIAN CONTACT DETAILS (please write IN CAPITAL LETTERS)

Forename(s):	*Surname(s):*	
Address:		
Phone:	*Fax:*	*E-mail:*

INFORMATION ABOUT VACCINATIONS AND INFECTIOUS DISEASES
Please remember to attach the relevant medical records (vaccination certificate with all the vaccines received since birth and laboratory reports – COMPULSORY) to this document*.

Hepatitis B – mandatory *

❑ **complete cycle (3 doses required)****

**** please attach lab report showing positive immunity for Hepatitis B (anti-HBs ≥10 mIU/mL).** *If the report does not meet the required levels, students are required to get a booster vaccine before arrival. Failing to do so may result in internship limitations.*

MMR (Measles/Mumps/Rubella) – mandatory*

❑ **complete cycle (2 doses required)** **OR** ❑ **attached lab report showing positive immunity (*serum IgG*) for Measles, Mumps, and Rubella** *(only if vaccination cycle is incomplete or absent because of illness)*

Varicella – mandatory*

❑ **complete cycle (2 doses required)** **OR** ❑ **attached lab report showing positive immunity for Varicella (Positive VZV IgG***)** *(only if vaccination cycle is incomplete or absent because of illness)*

****VZV IgG lab tests reliably detect seroconversion for infection by wild type virus but are not sensitive and specific enough to reliably detect seroconversion to vaccine.* https://www.cdc.gov/chickenpox/lab-testing/lab-tests.html

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Hepatitis C – **mandatory***		
Screening tests for antibody to HCV (anti-HCV) performed within the past 3 months (attach lab report)	❑ positive	❑ negative

Tuberculosis – mandatory* (please tick if the student have been BCG-vaccinated, then choose ***one of the two test options*** *below, a test performed within the past 12 months is required even if vaccination has been performed)*		
TB Vaccine (BCG)*	❑ yes	❑ no
Tuberculin Skin Test (Mantoux) performed within the past 12 months (attach report)	❑ *positive*	❑ *negative*
*IGRA test performed within the past 12 months (attach report) *IGRA is the test option to be chosen for vaccinated students*	❑ *positive*	❑ *negative*
HIV – **optional**		
HIV test performed within the past 3 months (attach lab report)	❑ positive	❑ negative
Covid-19 Vaccine- optional		
❑ Vaccinated (date of last vaccination: _____)	❑ never vaccinated	

MEDICAL AND HEALTH HISTORY

Please indicate if the patient suffers/has ever suffered any of the following conditions:

Previous infectious diseases	**No** ☐	**Yes** ☐	*If yes, please specify (Year):* ❑ *Tuberculosis* _____ ❑ *Measles* _____ ❑ *Mumps* _____ ❑ *Rubella*_____ ❑ *Chickenpox* _____ ❑ *Other* _____
COVID-19	**No** ☐	**Yes** ☐	*If yes, please specify (date):* *Attach diagnosis of history of the disease by health-care provider*
Cardiovascular (heart or blood vessels) diseases	**No** ☐	**Yes** ☐	*If yes, please specify:*
Respiratory diseases	**No** ☐	**Yes** ☐	*If yes, please specify:*
Musculoskeletal diseases	**No** ☐	**Yes** ☐	*If yes, please specify:*

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Diseases of the Nervous system (i.e. Epilepsy)	**No** ☐	**Yes** ☐	*If yes, please specify:*

Dermatologic conditions (i.e. contact dermatitis)	**No** ☐	**Yes** ☐	*If yes, please specify:*
Metabolic disorders (i.e. Diabetes)	**No** ☐	**Yes** ☐	*If yes, please specify:*
Mental illness or psychiatric disorders (i.e. anxiety, depression)	**No** ☐	**Yes** ☐	*If yes, please specify:*
Congenital or hereditary conditions	**No** ☐	**Yes** ☐	*If yes, please specify:*
Disability status (i.e. European Disability Card)	**No** ☐	**Yes** ☐	*If yes, please specify:*
Occupational accidents or diseases	**No** ☐	**Yes** ☐	*If yes, please specify:*
Any other diseases	**No** ☐	**Yes** ☐	*If yes, please specify:*
Long-term (current) use of medication (for three or more months)	**No** ☐	**Yes** ☐	*If yes, please specify:*

Please, attach a copy of the documentation relating to any conditions reported

Place, date ***Seal and signature of the Physician***

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