INTERNATIONAL CERTIFICATE OF VACCINATION

Date of issue:_____ 名前　姓：_____ 名：_____

Name First:_____ Last:_____

Date of birth:_____

Phone:_____

To Whom it may concern.

This is to certify that the person has received the following vaccination.

Vaccination in Mymedicalclinic		Month/day/Year	Month/day/Year	Month/day/Year	Antibody titerdate	Antibody titerdate	Result
☐	MR(Measles,Rubella)						
☐	HepatitisA						
☐	HepatitisB						
☐	Rabies						
☐	Meningitis（A,B,C,Y,W-135）						
☐	Varicella/Chickenpox						
☐	Mumps						
☐	Tetanus						
☐	Polio						
☐	Japanese Encepha litis						
☐	T-dap(Diphtheria,Pertussis,Tetanus)						
☐	DPT(Diphtheria,Pertussis,Tetanus)						
☐	DPT-IPV(Diphtheria,Polio,Pertussis,Tetanus)						
☐	Flu						
☐	Typhoid						
☐	Measles						
☐	Rubella						
☐	Tuberculin skin test						
Cheast X-Ray/Date: Result:Yes/No abnormality. It is not suspected infection of tuberculosis.							

This Certified that the above is truth.

Clinic Name　MY Medical Clinic Shibuya

Adress: NMF ShibuyaKouendori building5F

20-17,Udagawa-cho,shibuya-ku

Tokyo-metoropolis,Japan

Telephone:　+81-3-4579-9011

Doctor's Signature:_____


MY medical clinic