Formulierungshilfe für Impfnachweis

**Certificate of Immunization  
Re: Record of Immunization/Immunization History**

Name: Address:

Date of Birth: Sex:

**To Whom It May Concern:**

* This document is to certify that the above indicated individual underwent a medical check-up by [*PHYSICIAN’S NAME*] on [*DATE OF CHECK-UP*]. ***ODER***

The above-mentioned individual underwent a complete medical examination on [*DATE*].

* There are no medical reasons for restricting travel to and/or study in [*NAME OF COUNTRY*].
* Immunization was undertaken against the following diseases: ***ODER***

The above indicated individual has been immunized against:

* diphtheria
* Tetanus
* polio
* yellow fever
* measles/mumps/German measles
* The above indicated individual (***ODER*** [*NAME OF INDIVIDUAL*]) was vaccinated against [*NAME OF ILLNESS*] on [*DATE*].
* The blood test conducted on [*NAME OF INDIVIDUAL*] indicates that he/she has suffered from (***ODER*** been vaccinated against) [*NAME OF DISEASE*].
* The results of the tuberculosis tests were negative/positive.
* The examined individual shows no signs of acute or chronic illness/disease.
* The examined individual is in general good health, although exhibits signs of [*NAME PROBLEM*]. (***ODER***: he/she shows signs of [*NAME PROBLEM*]).

Examining physician:

Date of medical examination:

Physician’s signature and stamp: