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*__ indicate 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: _____