

IMMUNIZATION FORM

RETURN FORM TO ACADEMIC CHAIR'S OFFICE

Student Name: _____	Student Program: _____
Student ID: _____	Date of Birth: _____

A health care professional such as a doctor or nurse must complete and sign this form for you and indicate that all immunization requirements listed below are current.

It is recommended you retain a photocopy of this form for future employers. Students will be notified by the campus if requirements change or additional requirements are added. Please make sure to attach any supporting documentation.

Immunizations	Date Vaccine Given / Serology Results			Initials of Health Care Provider
Diphtheria/Tetanus/Pertussis (dTap) <i>Booster in past 10 years</i>				
Measles/Mumps/Rubella (MMR) <i>Two doses required if born after 1970</i>	#1			
	#2			
Varicella – History of Chicken Pox <i>(Provide proof of one, regardless of year of birth)</i>	Dose 1:			
	Dose 2:			
	Immune:			
	Confirmed Varicella:			
Hepatitis B** <i>Please note- If non- immune, documented evidence of first dose is required and it will be necessary for you to sign a waiver prior to your first practicum/placement.</i>	Dose 1:			
	Dose 2:			
	Dose 3:			
	Immune			
Exceptions: <i>Cosmetology; Esthetics and Spa Therapies, Community Recreation, Health Information Management</i>	Non-immune			
Tuberculosis Skin Test (TST) Two Step <i>TB Testing is required once every two years for the following programs:</i>	Date Given:	Date Read:	Result: mm	
	1 st Step:			
<i>Addictions & Community Outreach, Behavioral Interventions, Disability Supports & Services, Continuing Care, Dental Assisting Level II, Health Information Management, Medical Laboratory Technology, Mental Health Recovery and Promotion, Occupational Therapy/Physiotherapy Assistant, Therapeutic Recreation, Pharmacy Technician, Practical Nursing,</i>	2 nd Step:			

Health Care Professional (Doctor, Nurse, Pharmacist) who has reviewed supporting documentation & administered any outstanding vaccinations / tests as required:

Name (Please Print): _____

Title: _____

Signature: _____

Date: _____