

# Immunization Record

Note: The information contained in the Medical Assessment Form and the Immunization Record will be kept confidential and will only be reviewed by the Admissions Committee. It may be necessary to provide this information to clinical sites as proof of immunization and health status in order to secure clinical placements. In this situation the student will be informed by the Maritime School of Paramedicine.

### Tuberculosis Testing:

Note: Must have been completed within the last 12 months

Two step Tuberculin Skin Test:  Negative  Positive

If positive, were chest X-Rays completed?  Yes  No

Results \_\_\_\_\_

Has the individual received the BCG vaccine?  Yes  No

Has the individual received INH Therapy?  Yes  No

Name and Title of Health Care Professional: \_\_\_\_\_

Telephone: \_\_\_\_\_

Town, Province: \_\_\_\_\_

Relationship to Applicant (Eg. Family Physician): \_\_\_\_\_

Signature: \_\_\_\_\_

### Chicken Pox:

Has the individual has a history of Chicken Pox?  Yes  No

If yes, please provide date (if known): 

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If no, a vaccination against Varicella Zoster must be done. Please provide dates.

1. 

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2. 

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Name and Title of Health Care Professional: \_\_\_\_\_

Telephone: \_\_\_\_\_

Town, Province: \_\_\_\_\_

Relationship to Applicant (Eg. Family Physician): \_\_\_\_\_

Signature: \_\_\_\_\_

### Rubella:

Has the individual been vaccinated against Rubella?  Yes  No

Blood work must be completed to ensure immunity. Please provide date: 

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Was immunity successful?  Yes  No

Name and Title of Health Care Professional: \_\_\_\_\_

Telephone: \_\_\_\_\_

Town, Province: \_\_\_\_\_

Relationship to Applicant (Eg. Family Physician): \_\_\_\_\_

Signature: \_\_\_\_\_

### Rubeola:

Has the individual been vaccinated against Rubeola?  Yes  No

Blood work must be completed to ensure immunity. Please provide date: 

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Was immunity successful?  Yes  No

Name and Title of Health Care Professional: \_\_\_\_\_

Telephone: \_\_\_\_\_

Town, Province: \_\_\_\_\_

Relationship to Applicant (Eg. Family Physician): \_\_\_\_\_

Signature: \_\_\_\_\_

DPT:

Has the individual been immunized against DPT?  Yes  No

Please provide date: 

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Name and Title of Health Care Professional: \_\_\_\_\_

Telephone: \_\_\_\_\_

Town, Province: \_\_\_\_\_

Relationship to Applicant (Eg. Family Physician): \_\_\_\_\_

Signature: \_\_\_\_\_

Tetanus:

Has the individual received a Tetanus Booster?  Yes  No

Please provide date: 

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Name and Title of Health Care Professional: \_\_\_\_\_

Telephone: \_\_\_\_\_

Town, Province: \_\_\_\_\_

Relationship to Applicant (Eg. Family Physician): \_\_\_\_\_

Signature: \_\_\_\_\_

Hepatitis B:

Has the individual received vaccination against Hepatitis B?  Yes  No

Note: The applicant must have received a minimum of the first vaccination of this series

1<sup>st</sup>

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2<sup>nd</sup>

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3<sup>rd</sup>

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Name and Title of Health Care Professional: \_\_\_\_\_

Telephone: \_\_\_\_\_

Town, Province: \_\_\_\_\_

Relationship to Applicant (Eg. Family Physician): \_\_\_\_\_

Signature: \_\_\_\_\_

Influenza:

Note: Must have been completed within the last 12 months

Has this individual received vaccination against Influenza?  Yes  No

Please provide date: 

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Name and Title of Health Care Professional: \_\_\_\_\_

Telephone: \_\_\_\_\_

Town, Province: \_\_\_\_\_

Relationship to Applicant (Eg. Family Physician): \_\_\_\_\_

Signature: \_\_\_\_\_