



## IMMUNIZATION RECORD

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

TETANUS TOXOID and DIPHTHERIA TOXOID <small>(Reinforcing doses every 10 years)</small>	MOST RECENT BOOSTER DOSE GIVEN: Td or Tdap Date: _____		
POLIO VACCINE	MOST RECENT DOSE GIVEN: Date: _____		
RUBELLA	Rubella Vaccine: Date: _____	Rubella Antibody <sup>1</sup> : immune <input type="checkbox"/> non-immune <input type="checkbox"/>	Date Tested: _____
MEASLES: (Those born before 1970 are considered immune-please provide birth date above.)	Measles Vaccine: Date: _____	Measles Antibody <sup>1</sup> Date Tested: : immune <input type="checkbox"/> non-immune <input type="checkbox"/>	
MUMPS: (Those born before 1970 are considered immune-please provide birth date above.)	Mumps Vaccine: Date: _____	Mumps Antibody <sup>1</sup> immune <input type="checkbox"/> non-immune <input type="checkbox"/>	Date Tested: _____
CHICKEN POX: See Reverse	Chicken Pox Antibody: Date Tested: _____	immune <input type="checkbox"/> non-immune <input type="checkbox"/>	Or vaccine Dates
HEPATITIS B Vaccine: OR Antibody Titre <sup>1</sup> :	Dates: Dose 1: _____ Dose 2: _____ Dose 3: _____ Titre Date: _____ Result: immune <input type="checkbox"/> non-immune <input type="checkbox"/>		
TUBERCULOSIS CHEST X-RAY (within 1 year) if past history of Tuberculosis or 2-step (any date) -one step within one year prior to entering program	Date: (Chest X ray required for all positive TST within the last 2 years)	Step 1 Date: Results: (not to be read by student) Must be read within 48-72 hours	Step 2 Date: Results: (must be administered 7-21 days after step 1- not to be read by student) Must be read within 48-72 hours
		Result:  If positive, follow-up:	

Signature of Physician or Nurse: \_\_\_\_\_ Date: \_\_\_\_\_  
*(This document will not be accepted if signed by the student)*

Address: \_\_\_\_\_

**Note: Costs associated with form completion are the responsibility of the student.**

**Note: Students who cannot be immunized because of allergies, family planning/pregnancy or for other reasons must provide a physician's certificate to this effect.**

<sup>1</sup> If antibody is low or non-existent vaccine is required.