MEDAVIE HealthEd ÉduSanté

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IMMUNIZATION FORM

Medavie HealthEd is responsible to mitigate the risk of illness for its students and their patients. Students participate in patient care (sometimes in uncontrolled environments) where they may be exposed to or expose others to communicable diseases. This record serves as valid evidence that a student possesses the immunity they require to participate in the patient care process. **Therefore, it is important that the applicant and the Health Care Provider review this document in detail so as to appreciate its significance and relevance to our admission process.**

The evidence we accept as proof of immunity may include serology (blood work for the diagnostic identification of antibodies in blood serum) or completed public health immunization documentation. All hospitals and ambulance operations require verification of immunizations before placement. **Applicants with incomplete immunization records may be denied program admission and / or clinical & practicum placement.**

This record will be shared with the admissions team, as well as any hospital and ambulance operation where the student will be placed to participate in patient care.

☐ **Please note that if a clinical or practicum site requires further immunization reporting it will be up to the student to provide this information as soon as possible. If the student is unable to provide this information, they may not be permitted to attend that location (specific location or entire health authority) and may have to be placed in another area. Extra expenses regarding relocation and/or travel are at the students expense.**

Applicant Information

Full Name: _____

Date of Birth: _____

Program Name: _____

Program Location: _____

Course Start Date: _____

Tuberculosis (Mantoux/TB)

A 2-step Tuberculosis (Mantoux) test is required if never previously tested. If previously tested, documentation of the 2- step **and** a 1-step are required.
Step 1 must be dated within 1 year of the program start date.

A chest x-ray, within the last 12 months, is required if the applicant tests positive.
Date of chest x-ray: Results:

Date of Step 1	Date of Step 2	Date of repeated Step 1 (If applicable)	Health Care Provider Name and Address (Stamp Preferred)	Health Care Provider Signature
Date Injected: Date read: mm of induration:	Date Injected: Date read: mm of induration:	Date Injected: Date read: mm of induration:		

TDAP - Tetanus, Diphtheria & Pertussis

Tetanus booster with pertussis required **within the last 10 years.**

Date of last vaccination: _____ Booster Date: _____

Health Care Provider Signature: _____

Polio

Evidence of 3 doses of inactivated polio virus (IPV) or oral polio virus (OPV).

Not required unless "not immune" or documented proof is lacking and have travelled to Polio identified region

Date of Vaccination/History (MM/DD/YYYY)	Health Care Provider Name and Address (Stamp Preferred)	Health Care Provider Signature
First Dose: Second Dose: Third Dose:		

MMR - Measles (Rubeola), Mumps, Rubella (German Measles)

2 Doses are requied unless proven immunity in serology results.

Date of Vaccination/History (MM/DD/YYYY)	Booster(s) (If applicable)	Serology results	Health Care Provider Name and Address (Stamp Preferred)	Health Care Provider Signature
First Dose: Second Dose:	Date:	Date completed: Results:		

Varicella (Chicken Pox)

If documented history of contraction is prior to the one dose varicella immunization program in the corresponding Canadian province (see Appendix A), student is considered immune. If after this year or no prior history of contraction, two doses of varicella vaccine **or** serology is required.

Date of Vaccination/History (MM/DD/YYYY)	Booster(s) (If required)	Serology results	Health Care Provider Name and Address (Stamp Preferred)	Health Care Provider Signature
First Dose: Second Dose: **OR** Year of Contraction:	Date:	Date completed: Results:		

Hepatitis B

Hepatitis B vaccination and proof of immunity through serology report is mandatory. This is a series of 3 injections and titer, which are administered and tested over a 9 month period. A minimum of the first dose must be documented. In this case the student must also sign the waiver of immunity. If serology indicates non-immune than a booster may be required.

Date of Vaccination/History (MM/DD/YYYY)	Date of Booster(s) (If required)	Serology results	Health Care Provider Name and Address (Stamp Preferred)	Health Care Provider Signature
First Dose: Second Dose: Third Dose:	First Dose, If Required: Second Dose, If Required: Third Dose, If Required:	Date completed: Results:		

COVID-19 *Recommended, not required.*

COVID-19 vaccination against the SARS-CoV-2 virus by one of the vaccine options authorized for use in Canada.)

Date of Vaccination/History (MM/DD/YYYY)	Date of Booster(s) (If applicable)	Health Care Provider Name and Address (Stamp Preferred)	Health Care Provider Signature
Date:	Date:		

Influenza *Recommended, not required.*

Influenza (Flu shot) - Available during flu season is recommended for all students.

Date of Vaccination/History (MM/DD/YYYY)	Date of Booster(s) (If applicable)	Health Care Provider Name and Address (Stamp Preferred)	Health Care Provider Signature
Date:	Date:		

Appendix A

Table 1: Implementation of one dose varicella immunization programs in Canadian provinces and territories.

Province or Territory	Year of program implementation
Prince Edward Island	2000
Alberta	2001
Northwest Territories	2002
Nova Scotia	2003
Nunavut	2004
Ontario	2004
New Brunswick	2004
Manitoba	2004
Newfoundland and Labrador	2005
Saskatchewan	2005
British Columbia	2005
Quebec	2006
Yukon	2007

Important note: Program applicants should return this completed form and supporting documents to the Dartmouth Campus via Dropbox link provided.

Follow-up Appointment: _____

Applicant Name: _____

Applicant's Signature: _____

Date (MM/DD/YYYY): _____