

Immunization Record

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.

Applicant: _____

Program Name: _____

Date of Birth: _____

Program Location: _____

Immunization/Vaccine	Date of Vaccine/History	Date of Booster, if required	Serology (blood work)-provide documentation	Health Care Provider Name and Address (Stamp preferred)	Health Care Provider Signature
Tuberculosis – A 2-step (Mantoux) test is required if never previously tested. If previously tested, documentation of the 2-step and a 1-step are required. A chest x-ray, within the last 12 months, is required if the applicant tests positive. Date of chest x-ray: Results:	Step 1: Date injected: Date read: mm of induration: Step 2: Date injected: Date read: mm of induration:	Not applicable	Not applicable		
Tdap – Tetanus, Diphtheria & Pertussis <i>Tetanus booster with pertussis required within the last 5 years.</i>	Not applicable	Booster date:	Not applicable		
Polio - Evidence of 3 doses of inactivated polio virus (IPV) or oral polio virus (OPV). <i>Not required unless “not immune” or documented proof is lacking and have travelled to Polio identified region.</i>	First dose: Second dose: Third dose:	Not applicable	Not applicable		

Immunization/Vaccine	Date of Vaccine/History	Date of Booster, if required	Serology (blood work)-provide documentation	Health Care Provider Name and Address (Stamp preferred)	Signature
<p>MMR – Measles (Rubeola), Mumps, Rubella (German Measles) – two doses required if born after 1970.</p>	<p>First dose: Second dose:</p>	<p>Not applicable</p>	<p>Serology required proving immunity if unable to verify two documented doses. Serology results date:</p>		
<p>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 considered immune.</p> <p>If after this year or no prior history of contraction, two doses of varicella vaccine <u>or</u> serology is required.</p>	<p>Year of contraction: First dose: Second dose:</p>	<p>Not applicable</p>	<p>Serology required proving immunity if unable to verify two documented doses or history. Serology results date:</p>		
<p>Hepatitis B - vaccination and proof of immunity is mandatory.</p> <p>This is a series of 3 injections and titer, which are administered and tested over a 9 month period.</p> <p>A minimum of the first dose must be documented. In this case the student must also sign the below waiver of immunity.</p> <p>If serology indicates non-immune than a booster may be required.</p>	<p>First dose: Second dose: Third dose:</p>	<p>First dose, if required: Second dose, if required: Third dose, if required:</p>	<p>Serology required proving immunity (Hep B titer). Serology results date:</p>		
<p><i>I understand that I have only completed one or two of the three doses of the Hepatitis B vaccine and may not be immune. I also understand that in the clinical and/or practicum environment I may be exposed and potentially at risk of infection because of this.</i></p>					
Applicant Name		Date		Applicant Signature	

Immunization/Vaccine	Date of Vaccine/History	Date of Booster, if required	Serology (blood work)-provide documentation	Health Care Provider Name and Address (Stamp preferred)	Signature
<p>COVID-19 – vaccination against the SARS-CoV-2 virus by one of the vaccine options authorized for use in Canada.</p> <p>In addition to the date of each dose, please record which vaccine type was received – i.e Pfizer-BioNTech (Comirnaty®), Moderna (Spikevax®), AstraZeneca (Vaxzevria®), and/or Janssen.</p>	<p>First dose & vaccine type:</p> <p>First dose & vaccine type:</p>	<p>Booster date & vaccine type:</p> <p>Note: at this time, a booster or “third dose” of COVID-19 vaccine is only recommended for immunocompromised individuals.</p>	<p>Not applicable</p>	<p>Note: Proof of immunization from Public Health and/or other approved agencies (i.e. “CANImmunize”) will be deemed sufficient.</p>	

- **Important note:**
 - Nova Scotia & Saskatchewan program applicants should return this completed form and supporting documents to the Dartmouth Campus at 50 Eileen Stubbs Avenue, Unit 154, Dartmouth, NS, B3B 0M7.
 - New Brunswick program applicants should return this completed form and supporting documents to the Moncton Campus at 567 Boul. St. George Blvd, Moncton, NB, E1E 2B9.

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	2001
Nova Scotia	2002
Nunavut	2002
Ontario	2004
New Brunswick	2004
Manitoba	2004
Newfoundland and Labrador	2005
Saskatchewan	2005
British Columbia	2005
Quebec	2006
Yukon	2007