DOUGLAS COLLEGE

Faculty of Health Sciences
HEALTH CARE SUPPORT WORKER
Including Health Care Assistant and Community Mental Health Worker
IMMUNIZATION & TB RECORD

Please PRINT clearly

STUDENT #:_____

FULL NAME:_____
Surname First Name Second Name

Your Permanent Mailing Address
Street
City Prov._____
Postal Code_____
Telephone_____
Cell_____
Email _____

Local Person to Contact in the Case of Emergency
Name
Street_____
City Prov._____
Postal Code_____
Telephone_____
Cell_____

DEPARTMENT REQUIREMENTS
Participation in clinical experience requires assessment of your immunization status. You are required to meet Health Authority Requirements for immunizations for students in practice settings. If Health Authority immunization requirements are not met you will not have access to clinical agencies and, subsequently, the inability to complete required clinical courses.

INFORMATION
Immunizations can be obtained from your Family Physician, Walk-in Clinic Physician, local Public Health Unit, Nurse Practitioner or Travel Clinic.

Ensure Immunization Record is complete and signed to avoid delays in processing your application. Make your own copies*

PROOF OF IMMUNIZATION
You are responsible to keep a copy of your immunization record as you may be required to provide proof of immunization when in a clinical setting. . Copies of all immunization and lab serology documents need to be submitted along with the completed Immunization Record.

CONSENT (to be signed by the Applicant)
I hereby authorize (give permission to) my Family Physician/Nurse Practitioner or Walk-in Clinic Physician/ Nurse Practitioner to provide Douglas College Faculty of Health Sciences any information regarding my immunization, and any information and/or opinions regarding my health.

Applicant's Signature:_____ Date:_____

This record must be completed in full and returned by the deadline date indicated on your acceptance letter to:

DOUGLAS COLLEGE
David Lam Campus
Office of the Registrar
1250 Pinetree Way
Coquitlam, BC V3B 7X3

KEEP A COPY OF THIS FORM FOR YOUR RECORDS

Student Name (Please Print): _____ Student Number: _____

To the Applicant: You are required to complete the following immunizations. Immunizations are required for your own protection and the protection of patients and families you care for as a student. If Health Authority immunization requirements are not met you will not have access to clinical agencies and, subsequently, the inability to complete required clinical courses which would prevent your progression in the program. *If booster is required, serology should be done first as proof, as this can exempt you from additional medical fees.

A. Admission Requirements: items 1 & 2 are required prior to program admission

1. HEPATITIS B Immunity: (HBsAb Blood test results _____) Health Care Provider Signature:_____
OR

HEPATITIS B Vaccine: Primary Series (3 doses)

1st of Series	2nd of series	3rd of Series
DD MM YY	DD MM YY	DD MM YY
_____	_____	_____
Health Care Provider Initials	Health Care Provider Initials	Health Care Provider Initials
_____	_____	_____

2. TUBERCULOSIS Skin Test: Sept intake: not earlier than May 1; Jan intake: not earlier than Sept 1; May intake: not earlier than Jan 1).

Skin Test Result +ve___ -ve___ Date _____ Health Care Provider Signature:_____
OR

Chest X-Ray (required if skin test is positive):
Chest X-Ray Result: +ve___ -ve___ Date _____ Health Care Provider Signature:_____

B. Clinical Requirements: items 1 - 5 are required prior to clinical experiences - deadline for these is approximately one month into semester one – date provided during the program orientation.

1. TETANUS-DIPHTHERIA-PERTUSSIS (Tdap) Vaccine
Primary series with a TD (Tetanus/Diphtheria). Booster every 10 years

Primary Series	Booster
Month/Year	Day/Month/Year
_____	_____

2. POLIO Vaccine
Basic immunization series plus single booster dose 10 years after primary series. *This is required as a health care worker.
Those with no basic series should have the series completed regardless of interval since last dose

Primary Vaccine	Booster
Day/ Month/Year	Day/ Month/Yea
_____	_____

3. MEASLES-MUMPS-RUBELLA (MMR) Vaccine
Two doses if born on or after January 1, 1957 or immunity to MMR confirmed by RECENT SEROLOGY (report to be attached). *previously experienced illness still requires serology or booster.

1st Dose	2nd Dose	
Day/ Month/Year	Day/Month/Year	Day/Month/Year
_____	_____	_____

4. VARICELLA (CHICKENPOX) Vaccine
Two doses or natural immunity (have had the disease prior to 2004 either self-reported or physician diagnosed-serology not necessary).

1st Dose	2nd Dose	
Day/Month/Year	Day/Month/Year	Day/Month/Year
_____	_____	_____

5. INFLUENZA Required yearly beginning each fall. Day/Month/Year
_____

Signature of Public Health Nurse or Doctor or Nurse Practitioner: _____ Date _____
Please note: Each item/vaccination must be signed individually by a health care provider if not completed or recorded initially.