# IMMUNIZATION REVIEW

Health Sciences Students

**Student Health Services**
3700 Willingdon Avenue
Burnaby, BC V5G 3H2
**T** 604.432.8843 • **F** 604.431.7261

| BCIT ID No. | Program | Care Card Number | |
|---|---|---|---|
| Last Name | First Name & Initial | Maiden Name (if applicable) | |
| Address | | | |
| City | Province | Postal Code | Date of Birth (mm/dd/yy) |
| Country of Birth | If not Canada, what was your year of arrival? | Mother's Country of Birth | |
| Phone (include area code)<br>Permission to leave message ○ Yes ○ No | Cell | Email<br>Permission to send email message<br>○ Yes ○ No | |

**VACCINATION HISTORY (COMPLETING THIS SECTION IS REQUIRED.)**

| | |
|---|---|
| Have you ever been diagnosed with a serious medical condition? Explain. | ○ Yes ○ No |
| Do you regularly see a doctor for any on-going medical problems? Explain. | ○ Yes ○ No |
| Are you or have you ever received chemotherapy or radiation for a diagnosis of cancer? | ○ Yes ○ No |
| Are you taking any medications which contraindicate receiving vaccinations? | ○ Yes ○ No |
| Are you allergic to any medications or medical products? Explain. | ○ Yes ○ No |
| Are you allergic to any environmental agents like dust, grass or pollen? Explain. | ○ Yes ○ No |
| Are you allergic to any foods including eggs or egg products? Specify food and reaction. | ○ Yes ○ No |
| Are you allergic to Thimerosal (preservative in some contact lens solutions)? | ○ Yes ○ No |
| Have you had an unusual reaction to a past vaccination you received? Explain. | ○ Yes ○ No |
| Are you pregnant at this time or have you missed a period? | ○ Yes ○ No |
| Have you been at risk for blood borne illness due to exposure to occupational risk, tattoos, body piercing, blood or blood product transfusion, IV/intranasal drug use, sexual health risk factors (multiple partners)? | ○ Yes ○ No |
| Did you receive primary vaccinations as an infant or in early childhood? If unsure, please speak with your parent/guardian. | ○ Yes ○ No |

The information on this form will be part of your medical file. Your signature serves as consent for Student Health Service to contact you by email or phone to follow up on your immunization history as indicated above.

I certify the information is accurate and up-to-date.

| Student Signature | | Date |
|---|---|---|
| Name of Health Care Provider reviewing this document (print) | Signature of Health Care Provider | Date |



See next page to complete Immunization & Immunization Status Record

## IMMUNIZATION AND IMMUNIZATION STATUS RECORD

| Name | Date of Birth (mm/dd/yy) |
|---|---|
| | |

## TO COMPLETE THIS FORM

1. Ask your parents or local public health unit for childhood immunization records.
2. Take immunization records and this form to your doctor or public health nurse to review and complete.

**DATES TO BE IN DD/MM/YYYY FORMAT.** **PLEASE PROVIDE COPIES OF ALL DOCUMENTATION.**

### TETANUS/DIPHTHERIA

| Childhood primary series (5 doses, or 4 if fourth dose after age 4) | ○ Yes ○ No ○ No record ○ Record provided |
|---|---|
| ○ Tetanus Diptheria ○ Tetanus Diptheria Polio ○ Adacel recommended | Date of Last Tetanus |

### POLIO

| Childhood primary series (5 doses, or 4 if fourth dose after age 4) | ○ Yes ○ No ○ No record ○ Record provided |
|---|---|
| Date of last Polio | |

### MEASLES, MUMPS AND RUBELLA

| **Mandatory: 2 documented MMRs** | | ○ No record ○ Record provided |
|---|---|---|
| MMR #1 | MMR#2 | **SEROLOGY NOT ACCEPTED** |

### VARICELLA (CHICKEN POX)

| Hx of Disease Date<br>No titre required | | OR Varicella Titre Date<br>Results: ○ Positive ○ Negative ○ Record provided | |
|---|---|---|---|
| Adult Primary Series of 2 doses required if there is inadequate immunity | | | |
| Date (Dose #1) | Vaccine | Date (Dose #2) | Vaccine |
| | | | |

### HEPATITIS B

| Primary Series (3 doses) complete. Record dates below. | | | ○ Yes ○ No ○ No record ○ Record provided |
|---|---|---|---|
| Vaccine #1 Date | Vaccine #2 Date | Vaccine #3 Date | |
| | | | |

### MANDATORY HEPATITIS B SCREEN AND ANTIBODY TITRE

| Hep B Surface Ag | Hep B Surface Ab | Hep B Core Ab | **Copy of results to BCIT Student Health Services.** |
|---|---|---|---|
| | | | |

### MENACTRA (RECOMMENDED FOR MEDICAL LABORATORY STUDENTS)

| Date ○ Men C ○ Menactra | Flu Vaccine (January intake only) ○ Yes ○ No<br>**Record required.** |
|---|---|
| | |

An administration fee of $50 will be charged during the immunization review for Health Science students after commencing the program. Hepatitis B vaccine, Tuberculin skin test, Varicella vaccine and MMR vaccine will be provided as necessary.

**Forward this form and antibody results to: BCIT Student Health Services, SE16–127, 3700 Willingdon Avenue, Burnaby, BC, V5G 3H2 or fax to 604.431.7261**