



# School of Pharmacy

## Immunization Record Form

(Please refer to <https://uwaterloo.ca/pharmacy/undergraduate-students/post-admission-requirements/immunizations>)

**Student's Name:** \_\_\_\_\_

**To Physician/Health Centre:** Students are required to be immunized against the following diseases before they begin their first co-op work term. These requirements must be fulfilled in order to meet the requirements set forth by the School of Pharmacy, University of Waterloo.

Students must have a **two-step** Mantoux test by June 15 of their first academic year in the Pharmacy program.

**EXCEPTIONS:**

- If a student has had a negative Mantoux test in the past five years, a single step Mantoux test is to be administered
- If the student is known to be skin test positive, the Mantoux test is not recommended. Documentation of skin-test positive history and chest x-ray must be submitted.

A chest X-ray should be completed if the student develops symptoms or is exposed to an active tuberculosis case.

<b>IMMUNIZATION</b>	
<b>Hepatitis B</b>	Date of 1 <sup>st</sup> shot: _____ Date of 2 <sup>nd</sup> shot: _____ Date of 3 <sup>rd</sup> shot: _____
<b>Measles</b>	Immunization date: _____ <b>OR</b> Titre & Date: _____
<b>Mumps</b>	Immunization date: _____ <b>OR</b> Titre & Date: _____
<b>Rubella</b>	Immunization date: _____ <b>OR</b> Titre & Date: _____
<b>Polio</b>	Date of Primary Series: _____
<b>Varicella</b>	Known history? Yes ____ No ____ If Yes, approximate age or date: _____ If No: (VZV antibody test required), VZV titre & date: _____
Varicella vaccine dates: (Recommended if VZV antibody negative)	1 <sup>st</sup> shot: _____ 2 <sup>nd</sup> shot: _____
<b>Diphtheria/Tetanus (effective for 10 years)</b>	Date: _____ Date next booster due: _____

<b>Tuberculin Test</b>	Date	Results (mm of Redness & Induration)
Test # 1	_____	_____
Test # 2 (if required)	_____	_____
Chest X-Ray Date: Required if TB test is positive	_____	Notes: _____

Clinic/Health Centre Authorization: (name, address, and phone number of clinic/health care centre/hospital where form was completed)

\_\_\_\_\_  
\_\_\_\_\_

Signature of health care professional: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of health care professional: \_\_\_\_\_

Please upload completed form by **July 1st of Year One** in your RXpreceptor account under the Requirements section. Email [phrexper@uwaterloo.ca](mailto:phrexper@uwaterloo.ca) if you have any questions about completing this form.

**STUDENTS WHO FAIL TO COMPLY WITH IMMUNIZATION AND DOCUMENTATION REQUIREMENTS WILL NOT BE PERMITTED TO PARTICIPATE IN A NUMBER OF ACADEMIC COURSE REQUIREMENTS INCLUDING CO-OP WORK TERMS AND AS SUCH WILL SUFFER ACADEMIC PENALTY.**