coast mountain college

RECORD OF IMMUNIZATION & IMMUNE STATUS FOR HEALTH PROGRAM STUDENTS

Name _____ Date of Birth ___/___/___
Last First Initial MM DD YY

Address _____
Street City Province Postal Code

Phone (___) _____ E-Mail _____ Student # _____

Semester of Admission to program: _____ Program/location _____
Month Year

TETANUS/DIPHTHERIA

Childhood or adult primary series completed: Date of last dose: _____
MM/DD/YY

☐ **AND**
Date of booster dose if 10 or more years since last dose: _____
MM/DD/YY
OR

☐ Booster not applicable as < 10 years since last dose

OR ☐ Administration of adult primary series required (Tdap preferred but may not be publically funded)

Dose #1: _____ Dose #2: _____ Dose #3: _____
MM/DD/YY *MM/DD/YY* *MM/DD/YY*

Please note that a Tetanus/Diphtheria booster must be received once every 10 years. Students are responsible to obtain and submit proof of required boosters while registered in the NCBNP.

Tetanus/Diphtheria immunization requirements met: **MD/NP/PHN Signature:**

POLIO

Childhood or adult primary series completed: Date of last dose: _____
MM/DD/YY

☐ **AND**
Date of one time booster dose if 10 or more years since childhood or adult series: _____
MM/DD/YY
OR

☐ Booster not applicable as < 10 years since childhood or adult series

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OR ☐ Administration of adult primary series required

Dose #1: _____ Dose #2: _____ Dose #3: _____
MM/DD/YY *MM/DD/YY* *MM/DD/YY*

Polio immunization requirements met: **MD/NP/PHN Signature:**

MEASLES, MUMPS, and RUBELLA

☐ Two doses MMR: Dose #1: _____ Dose #2: _____
MM/DD/YY *MM/DD/YY*

OR ☐ Date confirming serology indicating immunity for:
Mumps: _____ Measles: _____ Rubella: _____
MM/DD/YY *MM/DD/YY* *MM/DD/YY*

MMR immunization AND/OR immune status requirements met: **MD/NP/PHN Signature:**

Considered immune to measles if birth date on or after January 1, 1970 (January 1, 1957 for health care workers) **AND**
• laboratory evidence of measles immunity; or
• documentation of 2 doses of a live measles vaccine at 12 months of age and older and given at least 4 weeks apart.

Considered immune to mumps if birth date on or after January 1, 1970 (January 1, 1957 for health care workers) **AND**
• prior clinical diagnosis of acute mumps and laboratory confirmation of same; or documentation of two doses of mumps containing vaccine

There is no age above which immunity against rubella can be assumed for health care workers or health care students.

HEPATITIS B

☐ Childhood or adult series completed:
Dose #1: _____ *MM/DD/YY* Dose #2: _____ *MM/DD/YY*
Dose #3 (if required based on product):_____ *MM/DD/YY*

AND ☐ Serology for anti-HBs ≥ 10 IU/L (required for all HC students) Date: _____ *MM/DD/YY*

OR ☐ If primary series complete, but serology < 10 IU/L
Administer one dose of vaccine: Date: _____ *MM/DD/YY*
AND
Repeat serology in 1 month: Date: _____ *MM/DD/YY*
If serology remains < 10 IU/L, complete the series of vaccine: Dose # _____ *MM/DD/YY* Dose #_____ *MM/DD/YY*
AND
Repeat serology in 1 month: Date: _____ *MM/DD/YY* Result of Serology: _____

No further vaccine after two series if non responder

Hepatitis B immunization AND immune status requirements met: **MD/NP/PHN Signature:**

VARICELLA (Chicken Pox)

☐ History of varicella disease occurring after 12 months of age (considered immune): Date of disease: _____ *MM/DD/YY*
A self-reported history of varicella is adequate for those born before 2004.

OR ☐ Serology for VZV IgG indicating immunity: Date: _____ *MM/DD/YY*

OR ☐ Two doses of varicella vaccine received: Dose #1: _____ *MM/DD/YY* Dose #2: _____ *MM/DD/YY*

Varicella immunization OR immune status requirements met: **MD/NP/PHN Signature:**

TUBERCULOSIS ☐ Tuberculin skin test within 6 months of practice education placement

Date Given: _____ *MM/DD/YY* Date Read: _____ *MM/DD/YY*
Result ☐ Negative _____ mm
OR
Result ☐ Positive _____ mm (**If positive, provide result of chest x-ray)**

OR ☐ Previous positive Tuberculin skin test**. Provide result of chest x-ray.**

TB skin testing should be completed on the same day as MMR immunization or after an interval ≥ 4 weeks.
Annual screening is highly recommended. It is the student's responsibility to notify the institution of TB status annually.

Tuberculosis screening test requirements met: **MD/NP/PHN Signature:**

Health Care Provider Information (MD, NP, or PHN)

*The health care provider information and signature is only confirming vaccines are up to date based on available vaccine records and current vaccine recommendations as per BCCDC for health care students. This signature does not confirm the signatory administered the above vaccines.

Name of HCP (Print): _____ Clinical Address/Stamp: _____

Professional Title: _____

HCP Signature: _____ Date: _____

I give permission to CMTN to have access to my immunization information (incomplete without signature).

_____ _____ _____
Student's Name (Print) ***Signature*** ***Date***

SUBMIT FORM TO CMTN ADMISSIONS ONCE COMPLETED. STUDENTS ARE REQUIRED TO KEEP A COPY FOR THEIR RECORDS. COPIES OF THIS FORM WILL NOT BE PROVIDED AFTER SUBMISSION.