JIBC
School of Health, Community & Social Justice
Health Sciences Division

Immunization Checklist

Student Name (print): _____ **Date of Birth:** _____/_____/_____
Last Name First Name Initial YYYY MM DD

All students with practice education experiences in any setting within a health care organization are expected to follow the screening expectations and recommended immunizations as set out in the Practice Education Guidelines for BC, Communicable Disease Prevention.

PLEASE READ: IMPORTANT INFORMATION ON HOW TO COMPLETE THE FORM

1. Check with your family physician or local public health unit for childhood immunization records.
2. Take your immunization records and this form to your physician or public health nurse to review your records and complete, sign and stamp this form.
3. Note: Serology testing is required for Hepatitis B and results of this can take up to 28 days to be processed.
4. **This form only needs to be submitted once to JIBC when it is complete. Incomplete forms will be returned to the student**.

REQUIRED IMMUNIZATIONS	Dates to be in **YYYY / MM / DD** format
TETANUS, DIPHTHERIA, PERTUSSIS	
TDP Primary Series	Dates: Dose 1: _____ Dose 2: _____ Dose 3: _____
Tetanus and Diphtheria Booster **within the last** 10 years	Date:
POLIO	
Primary Series	Dates: Dose 1: _____ Dose 2: _____ Dose 3: _____
Booster 10 years **after** primary series	Date:
MEASLES, MUMPS AND RUBELLA (MMR)	
Initial Dose	Date:
Secondary Dose or Booster	Date:
HEPATITIS B	
Primary Series (**may take up to 8 months**)	Dates: Dose 1: _____ Dose 2: _____ Dose 3: _____
Serology (**attach results**)	Date:
VARICELLA (CHICKEN POX)	
History of disease after 12 months of age if disease occurred before 2004	Approximate Year:
OR Varicella Titer	Date: Results: Positive ○ Negative ○
If negative, Varicella Vaccine (2 doses)	Dates: Dose 1: _____ Dose 2: _____

I certify that the information disclosed on this form is accurate as of this date.

Student Signature		**Date:**
Name of Health Care Provider completing this document (print)	**Signature of the Health Care Provider**	**Date:**

Health Care Provider or Physician's Stamp