



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](#).

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: _____ HBsAb Result: _____ IU/L <i>Note: HBsAb level < 10 IU/L is not considered protected</i>	
VARICELLA (CHICKEN POX)		
History of disease after 12 months of age if disease occurred before 2004	Approximate Year: _____	
OR Varicella Titer	Date: _____	Results: Positive <input type="radio"/> Negative <input type="radio"/>
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:

