IMMUNIZATION REPORT

Student Name _____ **Student #** _____

Telephone _____ **Email** _____

Student Address _____
Street City Province Postal Code

Must be submitted for admissions into Edenbrook College of Health, Business & Technology
IMMUNIZATION REQUIREMENTS (Mandatory except the Influenza vaccination)
(DOCTOR/PHYSICIAN/HEALTH CARE PROFESSIONAL TO COMPLETE, SIGN & STAMP)

It is mandatory that your doctor/health care professional properly complete, sign & stamp all the information outlined below. No exceptions!

1. TETANUS, DIPHTHERIA & PERTUSSIS *(Tdap/ADACEL/BOOSTRIX vaccine must be valid every 10 years. A booster is required for individuals whose last vaccination was 10 or more years ago)* *attach a yellow card or any immunization record.*

Immunization	*Date Given (mm / dd / yyyy)*
Tetanus, Diphtheria, Pertussis (TdaP)	
Tetanus, Diphtheria (Td)	

2. MEASLES, MUMPS & RUBELLA (MMR) (Booster dose must be administered if inadequate immunity)

Immunization	*Date Given (mm/dd/yyyy)*	*Results*
Measles Titre		☐*Reactive* ☐ *Indeterminate* ☐*Non-Reactive*
Mumps Titre		☐*Reactive* ☐ *Indeterminate* ☐*Non-Reactive*
Rubella Titre		☐*Reactive* ☐ *Indeterminate* ☐*Non-Reactive*

OR

Immunization	*Date Given (mm/dd/yyyy)*
MMR Dose #1	
MMR Dose #2	
MMR Booster (if needed)	

3. POLIOMYELITIS (Basic immunization series plus single booster dose 10 years after primary series). Those with no basic series should have the series completed regardless of interval since last dose. *Attach a yellow card or any immunization record.*

Immunization	*Date Given (mm/dd/yyyy)*
Dose #1	
Dose #2	
Dose #3	
Dose #4	
booster dose	

4. HEPATITIS B *(attach a copy of blood test report, check the box, document all doses, sign & stamp as outlined below)*

Immunization	*Date Given (mm/dd/yyyy)*	☐ Immunity/Reactive/Positive lab test result (**Note:** NO injections required)
Hepatitis B Titre		☐ Non-Immunity/Non-Reactive/Negative/Low (>0 or <10) lab test result (**Note:** it is mandatory that you *ATTACH* a copy of most recent "Antibody" laboratory blood test report and get the following doses as outlined below. Maximum of six Hep B doses in a lifetime)

AND

Immunization	*Date Given (mm/dd/yyyy)*
Hepatitis B Dose #1	
Hepatitis B Dose #2	
Hepatitis B Dose #3	

If the titer results show non-immune, the series must be given or repeated and additional blood work 1-month post-second series is required.

If Non-Immune, please complete Section B.

Section B: Second Series

Immunization	**Date Given (mm/dd/yyyy)**	***Result***
2nd Series Hepatitis B Titre		☐ Immune ☐ Non-Immune

AND

Immunization	*Date Given (mm/dd/yyyy)*
2nd Series Hepatitis B Dose #1	
2nd Series Hepatitis B Dose #2	
2nd Series Hepatitis B Dose #3	

5. TWO CONSECUTIVE STEP-TUBERCULOSIS SKIN TEST *(start after June 1, 2017 & see instructions below)*

- **First Time**-If you never had Two Consecutive Step-TB Skin Test done in a lifetime, it is mandatory that you complete and pay for Two Step-TB Skin Test.
- **No Chest X-ray only**-all students must provide proof of Two Consecutive Step-TB Skin Test done and we will **NOT** accept a Chest X-ray report only.
- **Failure to do TB Step 2 within 7-21 days after Step 1, you will need to redo both TB Skin Test again and extra fees will apply**.
- **Negative with less than (<10 mm)-**If you have **proof** of previous Two Consecutive Step-TB Skin Test and the result was both "**Negative",** do annual Step 1-TB Skin Test.
- **Positive with more than (> 10 mm)-**If you have proof of previous Two Consecutive Step-TB Skin Test and the result was **"Positive", NO more**

annual skin test or Chest X-ray required and your doctor needs to do annual physical exam and answer letters (A-F) below.

- **BCG vaccination**-If you had BCG vaccination it is **NOT a contraindication** for skin test, you are still required to provide proof and complete a Two Step-TB skin test.

PREVIOUS: STEP 1 TB SKIN TEST

_____/_____ _____/_____

(Date Given: mm / dd / yyyy) (Date Read: 48-72 hours after date given) (Induration size) (mm)

PREVIOUS: STEP 2 TB SKIN TEST *(7-21 days after Step-1)*

_____/_____/_____

(Date Given on opposite arm: mm / dd / yyyy) (Date Read: 48-72 hours after date given) (Induration size) (mm)

CURRENT: STEP 1 TB SKIN TEST

_____/_____/_____

(Date Given: mm / dd / yyyy) (Date Read: 48-72 hours after date given) (Induration size) (mm)

CURRENT: STEP 2 TB SKIN TEST *(7-21 days after Step 1)*

_____/_____/_____

(Date Given on opposite arm: mm / dd / yyyy) (Date Read: 48-72 hours after date given) (Induration size) (mm)

TB SKIN TEST POSITIVE MUST BE (MORE THAN >10 MM) INDURATION
DOCTOR/PHYSICIAN MUST DO ANNUAL PHYSICAL EXAM & ANSWER LETTERS (A-F) BELOW

	Result	***Date (mm/dd/yyyy)***
Chest X-ray (ATTACH a copy of the X-ray report valid every four years)		
History of disease	□ *Yes* □*No*	
Prior history of BCG vaccination (need documentation?	□ *Yes* □*No*	
Does this student have signs/symptoms of active TB on physical examination?	□ *Yes* □*No*	
INH Prophylaxis? ***Indicate Dosage:***	□ *Yes* □*No*	
Specialist Referred?	□ *Yes* □*No*	

6. VARICELLA (Chicken Pox) *Required for those with negative titers.*

□ First dose	*Given Date (mm / dd / yyyy):*	
□ Second dose *(must be administered at least 4 weeks after 1st dose)*	*Given Date (mm / dd / yyyy):*	
□ Varicella Titer: If you have no documented doses of Varicella vaccine, if you are unsure of your history of chickenpox disease, or you had disease after 2003, a titer must be completed.	*Given Date (mm / dd / yyyy):*	□ *Reactive* □ *Non- Reactive*

7. SEASONAL INFLUENZA VACCINE *(recommended not mandatory)*

The influenza vaccine is not mandatory; however, if an outbreak occurs at an assigned agency, and flu vaccine was not received, you may be denied access to the facility, thus jeopardizing the successful completion of your placement.

Seasonal Flu Shot	□ *Yes* □*No*	***Given Date (mm/dd/yyyy):***

8. COVID-VACCINATION *(Required)*

Covid-Vaccination	□ *Yes* □*No*	***First dose: Given Dates (mm/dd/yyyy):*** ***Second dose: Given Dates (mm/dd/yyyy):***

PHYSICIAN COMPLETING THE REPORT (MANDATORY):

_____

Physician Name Name of Clinic

_____

Complete Address Telephone No

_____

Physician Signature Date

MANDATORY
MEDICAL CLINIC STAMP HERE:

AGREEMENT FORM

Student Name _____

Program _____

I _____(Print Name) understand that any false statement is grounds for cancellation of admission.

I understand that the College has the right to cancel my admission privilege on the basis of medical information submitted or withheld. I understand that it is my responsibility to inform the appropriate Edenbrook College personnel
of any communicable disease, special need, exception, or medical condition which may place me at risk or pose a risk to others at Edenbrook College or at Clinical Placement.

_____

(Student Signature) **(Date)**

ELEMENT OF RISK

All experiential learning programs, such as field trips, clinical and field placements or job shadowing involve certain elements of risk. Injuries may occur while participating in this activity without any fault of the student, the clinical placement host or the College. By taking part in this activity, you are accepting the risk that you may be injured. Following the Health and Safety rules of your clinical placement is required.

By signing below you agree that you have reviewed the element of risk and are willing to comply with the Health and Safety Rules of your clinical placement.

If an injury should occur, it must be reported immediately to your supervisor and to your faculty. Completing Workers Safety Insurance Board forms and reporting any injury while participating in placement must take place within **72 hours** of occurrence.

_____

(Student Signature) **(Date)**