

### Immunization Checklist

Student Name (print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
LAST NAME FIRST NAME INITIAL YYYYY MM DD

The following Immunizations, based on **The Practice Education Guidelines for BC<sup>1</sup>** set out by the BC Academic Health Council, are required by healthcare students in BC doing practice education placements.

REQUIRED IMMUNIZATIONS		Dates to be in YYYY / MM / DD format
<b>TETANUS, DIPHTHERIA, PERTUSSIS</b>		
TDP Primary Series	Dates:	
Tetanus and Diphtheria Booster <b>within the last 10 years</b>	Date:	
<b>POLIO</b>		
Primary Series	Dates:	
Booster 10 years <b>after</b> primary series	Date:	
<b>MEASLES, MUMPS AND RUBELLA (MMR)</b>		
Initial Dose	Date:	
Secondary Dose or Booster	Date:	
<b>HEPATITIS B</b>		
Primary Series ( <b>may take up to 8 months</b> )	Dates:	
<b>Attach serology (blood test) results</b> showing anti-HBs ≥ 10 IU/L	Date:	
<b>VARICELLA (CHICKEN POX)</b>		
History of Disease > 12 months of age	Date:	
<b>OR</b> Varicella Titer	Date:	Results: Positive <input type="radio"/> Negative <input type="radio"/>
If negative, Varicella Vaccine (2 doses)		
Dose #1	Date:	
Dose #2	Date:	

**Tuberculosis:** You will be required to have a tuberculin skin test (TST) and, upon acceptance into the program, will be notified of when to have the test and submit proof. A Two Step TST is recommended if available, otherwise a negative TST is required.

**Influenza (flu):** It is recommended that you receive a flu vaccination during flu season, which generally starts in November and lasts until March each year. The vaccine is usually available in mid-October and you will be required to submit proof. You will also be required to carry proof of vaccination during practice education placements.

**COVID-19:** You must be fully immunized against COVID-19 and submit proof. You will also be required to carry proof of vaccination during practice education placements.

**I certify that this information is accurate and up-to-date.**

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

*Health Care Provider or  
Physician's Stamp*

<sup>1</sup> [http://hspcanada.net/docs/PEG/1\\_3\\_Immunization.pdf](http://hspcanada.net/docs/PEG/1_3_Immunization.pdf)