



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 <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:

