

School of Pharmacy

Immunization Record Form (Year 1)



UNIVERSITY OF WATERLOO
FACULTY OF SCIENCE
School of Pharmacy

Notes to Physician/Health Centre:

Students are required to be immunized against the following diseases before they begin their first co-op work term. This must be completed in order to meet the [post-admission requirements](#) set forth by the School of Pharmacy.

Students must also complete a **two-step** Mantoux TB skin test. **EXCEPTIONS** include the following:

- If a student has a **documented** negative two-step Mantoux test, only a one-step Mantoux test is to be administered.
- If the student is known to be skin test positive, the Mantoux test is not recommended. Documentation of skin-test positive history and chest x-ray results must be submitted.

A chest x-ray should be completed if the student develops symptoms or is exposed to an active tuberculosis case.

Notes to Student:

When visiting a physician or health centre to complete this form, bring to your appointment the following:

- Your immunization information available through your family doctor, your yellow immunization card, or your Public Health record.
- Copies of titre bloodwork results that verify your immunity (if previously completed).

In some instances, individuals who have been immunized may received titre results indicating non-immunity (known as vaccine non-responders). In this situation, please contact phrexper@uwaterloo.ca.

This immunization form must be completed, verified, and signed off by a healthcare professional.

Please upload your completed form in your [CORE ELMS](#) account under the Requirements menu. Email phrexper@uwaterloo.ca if you have any questions about completing this form.

STUDENTS WHO FAIL TO COMPLY WITH IMMUNIZATION AND DOCUMENTATION REQUIREMENTS MAY NOT BE PERMITTED TO PARTICIPATE IN A NUMBER OF ACADEMIC COURSE REQUIREMENTS INCLUDING CO-OP WORK TERMS AND AS SUCH ACADEMIC PENALTIES MAY APPLY.

STUDENTS WHO REQUIRE AN ACCOMMODATION MUST CONTACT ACCESSABILITY SERVICES AND NOTIFY THE SCHOOL'S DIRECTOR OF UNDERGRADUATE AFFAIRS.

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Student Name: _____ Student Number: _____

HEPATITIS B (immunization dates AND titre are required)	Date of 1 st dose (dd/mm/yy):	Date of 2 nd dose:	Date of 3 rd dose (if appl.):
	Date of titre (dd/mm/yy):	Result (check one): <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive	Level:
If Hepatitis B titre is non-reactive	Completion of second series? <input type="checkbox"/> Yes <input type="checkbox"/> No	Result (check one): <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive	Level:

MEASLES, MUMPS & RUBELLA (immunization dates OR titres are required)	Date of 1 st dose (dd/mm/yy):		Date of 2 nd dose:	Date of booster (if appl.):
		Date of titre (dd/mm/yy):	Result (check one):	Level:
	Measles		<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive	
	Mumps		<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive	
	Rubella		<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive	

VARICELLA (immunization dates OR titre are required)	Date of 1 st dose (dd/mm/yy):		Date of 2 nd dose:
	Date of titre (dd/mm/yy):	Result (check one): <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive	Level:

TETANUS, DIPHTHERIA & PERTUSSIS (effective for 10 years)	Previously immunized? (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last dose (dd/mm/yy):	Next booster due (yyyy):
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POLIO
Date of primary series (dd/mm/yy):

COVID-19	1st dose	2nd dose (if appl.)
Date received (dd/mm/yy):		
Name of vaccine:		

INFLUENZA (strongly recommended)
Date last received (dd/mm/yy):

TUBERCULIN TEST	Two-step TB skin test - Required unless previously completed or previously tested positive. If previously complete, indicate results below.		One-step TB skin test - Required if documented two-step more than 12 month ago.
	Step 1	Step 2	Step 1
Date of test (dd/mm/yy):			
Date read:			
Result (check one):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Induration (mm):			
Chest x-ray date: (required if skin test positive):		X-ray results/notes:	

Clinic/Health Centre Authorization: (Name, address, and phone number where form was completed)		
Healthcare Professional:		
_____	_____	_____
(Print name)	(Signature)	(date)