

School of Pharmacy

Immunization Record Form (Patient Care Rotations)



UNIVERSITY OF WATERLOO
FACULTY OF SCIENCE
School of Pharmacy

Notes to Physician/Health Centre:

Students are required to have up-to-date immunization health records before starting patient care rotations (clinical placements) with the School of Pharmacy.

Students must complete a **one-step** Mantoux TB skin test.

- Exception: If the student is known to be skin test positive, the Mantoux test is not recommended. Documentation of chest x-ray results must be submitted.

Students must have a lab titre confirmation of Hepatitis B immunity on either their *Immunization Record Form (Year 1)* or a recent test.

Notes to Student:

Students must review site-specific requirements within CORE ELMS before completing this immunization form as BOTH this form and a site-specific immunization form may need to be completed.

If a practice site requires a copy of immunization forms, make sure to send this form AND the *Immunization Record Form (Year 1)*.

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

- Your School of Pharmacy Immunization Record Form (Year 1) with any additional documentation, immunization information available through your family doctor, your yellow immunization card, your Public Health record
- Copies of lab results that verify your immunity (if previously completed).

This form is used for guidance to outline the requirements that must be completed.

Students are allowed to submit alternate documentation outlining completion of requirements in lieu of submitting this form, i.e., a signed document from a health care centre with TB test results listed.

Students must upload their completed immunization form (or alternate documentation) by **December 31st** into their [CORE ELMS](#) account under the Requirements section. Email pharmacy.rotations@uwaterloo.ca with 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 PATIENT CARE ROTATIONS AND AS SUCH ACADEMIC PENALTIES MAY APPLY.

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

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Student Name: _____ Student Number: _____

HEPATITIS B MEASLES, MUMPS & RUBELLA TETANUS, DIPHTHERIA & PERTUSSIS POLIO VARICELLA TUBERCULIN TEST – proof of 2 step test	Please see School of Pharmacy <i>Immunization Record Form (Year 1)</i> and affiliated documents for verification of immunity
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TUBERCULIN TEST (one-step TB test <u>OR</u> chest x-ray required) tests must be less than 12 months old at the start date of last rotation	Test date (dd/mm/yy):	Read date:	Result (check one): <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Induration (mm):
	Date of chest x-ray (dd/mm/yy):		Result (check one): <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	X-ray results/notes (or attach report):

INFLUENZA (strongly recommended and may be required for specific practice sites)
Date last received (dd/mm/yyyy):

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

Some students may also need to complete additional requirements below. Please check *the Immunization Record Form (Year 1)* to determine if you need to complete these additional requirements.

Hepatitis B – if you required a booster series after completing your Year 1 form, please list the dates below as well as subsequent lab results indicating immunity.

HEPATITIS B (immunization dates <u>AND</u> titre are required)	Date of 1st dose (dd/mm/yy):	Date of 2nd dose:	Date of 3rd dose (if applicable):
	Date of titre (dd/mm/yy):	Result (check one): <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive	Level:

Tetanus, Diphtheria & Pertussis – check your Year 1 form to determine whether a booster is required (i.e., greater than 10 years since your last dose). Arrange for booster if next dose is due before the end of the program.

TETANUS, DIPHTHERIA & PERTUSSIS (effective for 10 years)	Date of last dose (dd/mm/yy):	Next booster due (yyyy):
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Clinic/Health Centre Authorization:
(Name, address, and phone number where form was completed)

Healthcare Professional:

(Print name) (Signature) (date)