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.

School of Pharmacy
Immunization Record Form (Year 1)

UNIVERSITY OF WATERLOO
FACULTY OF SCIENCE
School of Pharmacy

Student Name:_______________________________ **Student Number:**___________________________

HEPATITIS B (Titre is required AND immunization dates, if known)	Date of titre (dd/mm/yy):	Result (check one):	Level (if avail.):
		☐ Reactive ☐ Non-Reactive	
	Date of 1st dose (dd/mm/yy):	Date of 2nd dose (dd/mm/yy):	Date of 3rd dose (if appl.)
If Hepatitis B titre is non-reactive	**Completion of second series?**	**Result** (check one):	**Level** (if avail.):
	☐ Yes ☐ No	☐ Reactive ☐ Non-Reactive	

MEASLES, MUMPS & RUBELLA (Immunization dates OR titres are required)	Date of 1st dose (dd/mm/yy):		Date of 2nd dose:	Date of booster (if appl.):
		Date of titre (dd/mm/yy):	Result (check one):	Level (if avail.):
	Measles		☐ Reactive ☐ Non-Reactive	
	Mumps		☐ Reactive ☐ Non-Reactive	
	Rubella		☐ Reactive ☐ Non-Reactive	

VARICELLA (Immunization dates OR titre are required)	Date of 1st dose (dd/mm/yy):		Date of 2nd dose:
	Date of titre (dd/mm/yy):	Result (check one):	Level (if avail.):
		☐ Reactive ☐ Non-Reactive	

TETANUS, DIPHTHERIA & PERTUSSIS (effective for 10 years)	Previously immunized? (check one):	Date of last dose (dd/mm/yy):	Next booster due (yyyy):
	☐ Yes ☐ No		

POLIO	
Date of primary series (dd/mm/yy):	

COVID-19	1st dose	2nd dose (if appl.)	Booster dose (most recent)
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):	☐ Positive ☐ Negative	☐ Positive ☐ Negative	☐ Positive ☐ 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)*