RECOMMENDED IMMUNIZATIONS FOR
HEALTH CARE ASSISTANT PROGRAM STUDENTS

Name ____ Date of Birth _____/_______/_______
Last First Initial MM DD YYYY

Address ____
Street City Province Postal Code

Phone (______)__________________________________ E-Mail ____

Please complete and submit this form to the Admission Office at Northwest Community College, 5331 McConnell Ave, Terrace BC V8G4X2

Failure to do so may jeopardize the student's ability to progress through the Program, since students who do not receive recommended Immunizations may be excluded from clinical placements.

HEPATITIS B

Complete immunization series received in Grade 6: YES________ (Completed Year__________) NO_____________

If NO: Immunization #1__________________ Immunization #2__________________ Immunization #3__________________
MM/DD/YY MM/DD/YY MM/DD/YY

TITRE, if required (to be obtained through a family physician) ___________________ Date______________________
MM/DD/YY

MEASLES, MUMPS, RUBELLA

Initial immunization: Date____________________________
MM/DD/YY

Second immunization: Date____________________________
MM/DD/YY

TITRE, if required (to be obtained through a family physician) ___________________ Date ______________________
MM/DD/YY

POLIO

Primary series (3 doses) in early childhood: YES____________(Year___________) NO_____________

Adult primary series, **if required**: 1st DOSE ________________________
MM/DD/YY

2nd DOSE________________________
MM/DD/YY

3rd DOSE ________________________
MM/DD/YY

TETANUS, DIPHTHERIA

Date of last vaccination: Date____________________________
MM/DD/YY

Date of repeat vaccination (if >10 years since previous): Date____________________________
MM/DD/YY

TUBERCULOSIS SKIN TEST Must be within one year of date of admission.

Date Given: ______________________ Date Read: ______________________
MM/DD/YY MM/DD/YY

RESULTS: Negative: ________ // ______________ mm.

Positive: ________ // ______________ mm.

If POSITIVE, attach CHEST X-RAY REPORT, current to within one year of admission.

VARICELLA Required if there is NO KNOWN HISTORY of Chicken Pox disease.

TITRE (must be obtained through a family physician): ______________________ Date ______________________
MM/DD/YY

Immunization based on titre: 1st DOSE: ______________________
MM/DD/YY

2nd DOSE: ______________________
MM/DD/YY

If receiving immunization at the Health Unit, please provide a copy of your titre.

This is to certify that ______________________ has received the recommended immunizations as indicated above.
Name of Applicant

Provincial Health Unit or Physician Stamp Required

____
M.D. or R.N. (Please print name)

____
M.D. or R.N. (Signature)

____
Date

I certify that the above information is accurate.

______________________ ______________________
Applicant Date