



Immunization and Mantoux Requirements

Surname:		Given Name:	
DOB: (Day/Month/Year)	Phone Number:	Email address:	
Provincial Health Card #		Country/Province:	

Immunizations

Tdap (primary series) <small>Diphtheria/Tetanus/Pertussis (Initial 3 doses)</small>	Date of 1st dose:	Date of 2nd dose:	Date of 3rd dose:
Tdap Booster (Must have received within the last 10 years)	Date of Booster:		
Polio (primary series)	Date of 1st dose: <input type="checkbox"/> Oral <input type="checkbox"/> fIPV <input type="checkbox"/> IPV	Date of 2nd dose: <input type="checkbox"/> Oral <input type="checkbox"/> fIPV <input type="checkbox"/> IPV	Date of 3rd dose: <input type="checkbox"/> Oral <input type="checkbox"/> fIPV <input type="checkbox"/> IPV
MMR (Measles/Mumps/Rubella) <small>If no vaccines received, MMR titres required</small>	Date of 1st dose:		Date of 2nd dose:
Varicella (Chicken Pox) <small>If no vaccines received, Varicella titre required</small>	Date of 1st dose:		Date of 2nd dose:
Hepatitis B <small>(3 dose requirement)</small>	Date of 1st dose:	Date of 2nd dose:	Date of 3rd dose: Date of Booster(s) if needed:
Influenza <small>(Recommended yearly)</small>	Date of last influenza vaccine:		
COVID-19 <small>(Recommended record of primary series)</small>	Dates of primary series:		Additional vaccine dates:

Two Step Tuberculosis (TB) Test (Mantoux)

Step One	Date Given: _____ Date Read: _____	Results: _____mm	Chest X-Ray: Yes __ No __ Results (attached):
Step Two	Date Given: _____ Date Read: _____	Results: _____mm	IGRA: Yes __ No __ Results (attached):
TB skin test (within the last 12 months)	Date Given: _____ Date Read: _____	Results: _____mm	BCG vaccine: Yes __ No __

TITRE REQUIREMENTS (please attach a copy of the results)

Varicella Titre (If history of disease or no record of immunization)	Draw Date: Attach documentation	Results
Measles Titre (If not immunized with 2 doses of MMR vaccine)	Draw Date: Attach documentation	Results
Rubella Titre (If not immunized with 2 doses of MMR vaccine)	Draw Date: Attach documentation	Results
Mumps Titre (If not immunized with 2 doses of MMR vaccine)	Draw Date: Attach documentation	Results
Hepatitis B Titre (post-immunization serologic testing required)	Draw Date: Attach documentation	Results

Signature: _____ Date: _____
(Public Health Nurse/Employee Health Nurse/Nurse Practitioner/Physician)



Immunization and Mantoux Requirements

This document must be reviewed and signed by a Public Health Nurse, Employee Health Nurse, Nurse Practitioner or Physician.

Learners who fail to submit the following information in this form will not be allowed to proceed into their clinical rotation.

Helpful Information:

Mantoux/TB Skin test

A TB skin test within the last 12 months is required. If you have never had a 2-Step TB skin test, then this test will be required. If you have documentation of a previous 2-Step TB Skin Test (please submit documentation), a single TB skin test should be performed within the last 12 months, since a 2-Step TB skin test is required only once. If you have a history of a positive TB skin test, do not have another TB skin test, but documentation of a chest x-ray will be required within the last 12 months. If you had IGRA blood work done, please provide documentation. If you required and received treatment for TB, please provide documentation from your health care provider.

Measles/Mumps/Rubella/Chicken Pox

It is recommended that all Healthcare Workers (HCW) be immune to measles, mumps, rubella and chicken pox. HCW's, regardless of their year of birth, should receive two doses of MMR and varicella vaccines if they do not have one or more of the following: documented evidence of receiving two doses of measles, mumps, rubella and chicken pox-containing vaccine; or laboratory evidence of immunity; or a history of laboratory confirmed of each disease.

Influenza Immunization

Recommended annually to comply with HPEI Respiratory Illness (COVID-19 and Influenza) Immunization and Management Policy. Documentation is required annually.

Immunization and Mantoux history (page 1) to be completed by Public Health Nurse, Nurse Practitioner or Physician.
Responsibility disclaimer (page 2, below) to be completed by applicant.

I am aware that it is my responsibility to ensure that the information provided is accurate, complete and up to date.

I am aware that as a Healthcare Worker it is my responsibility to stay up to date with my immunizations to decrease my own risk of illness, as well as the risk of death and other serious outcomes among patients/clients.

Signature: _____ Date: _____