



People Health and Wellbeing (PHW)
IMMUNIZATION RECORD
 Learner/Instructor

PLEASE PRINT

Last Name: _____ First Name: _____

Preferred Name: _____ Date of Birth (DD/MM/YYYY): _____

TUBERCULOSIS (TB) STATUS

Tuberculin testing: 2-step required. 2nd step must be given 1-4 weeks after 1st test in opposite arm if 1st test is less than 10mm induration.

1 st Step:	Date planted:	Date read:	Induration (mm)
2 nd Step:	Date planted:	Date read:	Induration (mm)

If a 2-step test was administered more than 12 months prior to your start date, an additional 1-step test will be required. If a 2 step TST has not been completed and a 1-step test was administered in the last 12 months and is negative (<10mm induration), an additional 1-step test will be required within 12 months of start date. This would qualify as a 2 step TST.

1-step:	Date planted:	Date read:	Induration(mm)
1-step:	Date planted:	Date read:	Induration(mm)

Chest x-ray: Required if learner has, or previously had, a positive tuberculin skin test (TST).

X-ray Date:	Result / Comments:
-------------	--------------------

LAB-CONFIRMED IMMUNITY/IMMUNIZATION STATUS

Measles	Laboratory evidence of immunity (titres)	Measles: Date of lab test:	Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
	OR 2 MMR vaccines	Date of 1 st MMR:	Date of 2 nd MMR <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
Mumps	Laboratory evidence of immunity (titres)	Mumps: Date of lab test:	Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
	OR 2 MMR vaccines given at least 4 weeks apart	Date of 1 st MMR:	Date of 2 nd MMR <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
Rubella	Laboratory evidence of immunity (titres)	Rubella: Date of lab test:	Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
	OR 1 MMR vaccine on or after 1 st birthday		Date of MMR: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
Varicella	Laboratory evidence of immunity (titres)	Varicella: Date of lab test:	Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
	OR Varicella vaccine	Date of 1 st dose:	Date of 2 nd dose:



People Health and Wellbeing (PHW)
IMMUNIZATION RECORD
 Learner/Instructor

	(2 doses required)		<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
Hepatitis B	Laboratory evidence of immunity (antibody titre must be provided if vaccinated)	Date of lab test:	Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
	Vaccination not mandatory but highly recommended	Received 3 doses of vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Dose #1
			Date Dose #2
			Date Dose #3
Date of booster			

Tetanus/Diphtheria/Pertussis (Tdap)	Immunization status is recommended	<input type="checkbox"/> Tdap Date: _____
Tetanus/Diphtheria (Td)	Immunization status is recommended	<input type="checkbox"/> Td Date: _____
COVID-19	Immunization status is recommended	Date Dose #1
		Date Dose #2
		Date of last booster
Influenza	Immunization status is mandatory	Date of last vaccine: _____

Learner/Instructor (printed name): _____

I hereby authorize my Treating Professional (as below) to release the above information to
 (institution name / instructor name) _____

Learner/Instructor Signature _____ Date _____

This form was completed by (Treating Professional **printed** name): _____

Signature/Stamp _____ Date _____