



IMMUNIZATION REVIEW

Health Sciences Students

Student Health Services
 3700 Willingdon Avenue
 Burnaby, BC V5G 3H2
 T 604.432.8843 • F 604.431.7261

BCIT ID No.	Program	Care Card Number	
Last Name	First Name & Initial	Maiden Name (if applicable)	
Address			
City	Province	Postal Code	Date of Birth (mm/dd/yy)
Country of Birth	If not Canada, what was your year of arrival?	Mother's Country of Birth	
Phone (include area code)	Cell	Email	
Permission to leave message <input type="radio"/> Yes <input type="radio"/> No		Permission to send email message <input type="radio"/> Yes <input type="radio"/> No	

VACCINATION HISTORY (COMPLETING THIS SECTION IS REQUIRED.)

Have you ever been diagnosed with a serious medical condition? Explain.	<input type="radio"/> Yes <input type="radio"/> No
Do you regularly see a doctor for any on-going medical problems? Explain.	<input type="radio"/> Yes <input type="radio"/> No
Are you or have you ever received chemotherapy or radiation for a diagnosis of cancer?	<input type="radio"/> Yes <input type="radio"/> No
Are you taking any medications which contraindicate receiving vaccinations?	<input type="radio"/> Yes <input type="radio"/> No
Are you allergic to any medications or medical products? Explain.	<input type="radio"/> Yes <input type="radio"/> No
Are you allergic to any environmental agents like dust, grass or pollen? Explain.	<input type="radio"/> Yes <input type="radio"/> No
Are you allergic to any foods including eggs or egg products? Specify food and reaction.	<input type="radio"/> Yes <input type="radio"/> No
Are you allergic to Thimerosal (preservative in some contact lens solutions)?	<input type="radio"/> Yes <input type="radio"/> No
Have you had an unusual reaction to a past vaccination you received? Explain.	<input type="radio"/> Yes <input type="radio"/> No
Are you pregnant at this time or have you missed a period?	<input type="radio"/> Yes <input type="radio"/> No
Have you been at risk for blood borne illness due to exposure to occupational risk, tattoos, body piercing, blood or blood product transfusion, IV/intranasal drug use, sexual health risk factors (multiple partners)?	<input type="radio"/> Yes <input type="radio"/> No
Did you receive primary vaccinations as an infant or in early childhood? If unsure, please speak with your parent/guardian.	<input type="radio"/> Yes <input type="radio"/> No

The information on this form will be part of your medical file. Your signature serves as consent for Student Health Service to contact you by email or phone to follow up immunization program as indicated above.

I certify the information is accurate and up-to-date.

Student Signature	Date
Name of Health Care Provider reviewing this document (print)	Signature of Health Care Provider
	Date

IMMUNIZATION AND IMMUNIZATION STATUS RECORD

Name	DOB
------	-----

TO COMPLETE THIS FORM

1. Ask your parents or local public health unit for childhood immunization records.
2. Take immunization records and this form to your doctor or public health nurse to review and complete.

DATES TO BE IN DD/MM/YYYY FORMAT.**PLEASE PROVIDE COPIES OF ALL DOCUMENTATION.****TETANUS/DIPHTHERIA**

Childhood primary series (5 doses, or 4 if fourth dose after age 4)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No record <input type="radio"/> Record provided
<input type="radio"/> Tetanus Diptheria <input type="radio"/> Tetanus Diptheria Polio <input type="radio"/> Adacel recommended	Date of Last Tetanus

POLIO

Childhood primary series (5 doses, or 4 if fourth dose after age 4)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No record <input type="radio"/> Record provided
Date of last Polio	

MEASLES, MUMPS AND RUBELLA

Mandatory: 2 documented MMRs	<input type="radio"/> No record <input type="radio"/> Record provided
MMR #1	MMR#2
Serology NOT required	

VARICELLA (CHICKEN POX)

Hx of Disease Date No titre required	OR Varicella Titre Date Results: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Record provided		
Adult Primary Series of 2 doses required if there is inadequate immunity			
Date (Dose #1)	Vaccine	Date (Dose #2)	Vaccine

HEPATITIS B

Primary Series (3 doses) complete. Record dates below.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No record <input type="radio"/> Record provided		
Vaccine #1 Date	Vaccine #2 Date	Vaccine #3 Date	

MANDATORY HEPATITIS B SCREEN AND ANTIBODY TITRE

Hep B Surface Ag	Hep B Surface Ab	Hep B Core Ab	Copy of results to BCIT Student Health Services.
------------------	------------------	---------------	---

MENACTRA (RECOMMENDED FOR MEDICAL LABORATORY STUDENTS)

Date	<input type="radio"/> Men C <input type="radio"/> Menactra	Flu Vaccine (January intake only) Record required.	<input type="radio"/> Yes <input type="radio"/> No
------	--	--	--

An administration fee of \$35 will be charged during the immunization review for Health Science students after commencing the program. Hepatitis B vaccine, Tuberculin skin test, Varicella vaccine and MMR vaccine will be provided as necessary.

Forward this form and antibody results to: BCIT Student Health Services, SE16-127, 3700 Willingdon Avenue, Burnaby, BC, V5G 3H2 or fax to 604.431.7261