Record of Immunization

Name: _____ DOB: _____
Last Name First Name Middle Initial DD / MMM / YYYY

Home or Cell number: (_____) _____-_____ Student ID: _____

Program: _____ Clinical Start Date (If known): _____

Tetanus, Diphtheria & Pertussis	Polio	Measles, Mumps & Rubella	Varicella
Dates of primary series: #1 _____ #2 _____ #3 _____ Booster: Td / dTap: _____ (circle one) (date)	☐ Not required for this program: Date: _____ Dates of primary polio series: #1 _____ #2 _____ #3 _____ Booster: _____ (date)	MMR dates: #1 _____ #2 _____ Measles Date: _____ Mumps Date: _____ Rubella Date: _____	☐ Had disease and is born in Canada Immunization date(s): _____ _____ ☐ Positive serology on: Date: _____ ☐ Sent for serology: Date: _____ (***Results will be mailed to student***)

Hepatitis B			COVID-19 / Influenza
☐ Not required for this program: Date: _____ Dates of primary hep B series: #1 _____ #2 _____ #3 _____	Booster(s), if necessary: Date: _____ Date: _____ Date: _____	☐ Hep B vaccine not recommended for student ☐ Positive serology on: Date: _____ ☐ Sent for serology: Date: _____ (***Results will be mailed to student***)	☐ COVID/19 Vaccine 1st dose Date:_____ ☐ COVID/19 Vaccine 2nd dose (if applicable) Date: _____ **Influenza vaccine:** Date:_____

TB / Mantoux Skin Test	
☐ Not indicated for student : _____ (date)	☐ Previous positive - Sent for chest x-ray: _____ ***(Results will be mailed to student)*** (date)
TB Testing: 1st test _____ Read: _____ Result: _____ mm (date) (date) 2nd test _____ Read: _____ Result: _____mm (*if required*) (date) (date)	**Follow-up:** Sent for chest x-ray: Date: _____ ***(Results will be mailed to student)***

Please note: Your school or agency will NOT receive a copy of any mailed results.

Record of Immunization

Name: _____ Student ID:_____

Last Name First Name Middle Initial

Healthcare Professional Verification

This verifies the above individual has completed the **first dose** of recommended immunizations/health tests as per Alberta Health Standards.

Health Unit Stamp

_____ _____

RN Signature Date

This verifies the above individual has met **all** recommended immunizations/health tests as per Alberta Health Standards.

Health Unit Stamp

_____ _____

RN Signature Date

School Verification

_____	_____	_____	_____
Name/Signature	Date	Name/Signature	Date