Dear TRU Nursing Student:

Immunization protects clients, health care workers/students from the potentially debilitating complications of communicable or infectious diseases. All health care workers, including students, should be protected against vaccine preventable diseases. Non-immunized students will not be allowed in the practice setting if there is an outbreak, hence impeding their success in the program. Plus, practice facilities my not accept unvaccinated students on a unit.

The TRU / TRU-OL School of Nursing Student Immunization Record can sometimes take **1 to 6 months** to complete. Please start the process for necessary immunizations to meet the Accepted Student requirements once you received confirmation letter. Your immunizations and record of same needs to be started and submitted **before** your program commences.

1. **First,** have a TB Skin test as other vaccines can delay when this test can be done.
   a) This test is not provided free. Make an appointment with a Travel Medicine and Vacation Centre at 1.888.288.8682 or email at: http://www.tmvc.com/
   b) TB skin tests require 2 visits, 48 hours apart. A chest x-ray may be required & can take 2-4 weeks for results.
   c) Have the Travel Medicine nurse complete the TB test section at the top of page 2.

2. Determine your Immunization Status
   a) Try to locate all your personal immunization records. Check with your parents, the local Health Unit, or your physician for your immunization records.
   b) If you are unable to locate your records, make an appointment with either a Public Health Unit Immunization clinic, Nurse Practitioner or your physician to determine what immunizations you may still require and if any blood tests may be needed to determine immunity.
   c) Bring your immunization information (if available) and this Nursing Student Immunization Record to your appointment with the Public Health Nurse.
   d) As a student in a health care program, vaccines are provided free of charge.
   e) Have the **Public Health Nurse/Nurse Practitioner/Physician complete, with appropriate dates, and sign** the certification section on page 3.
   f) Some vaccinations may or may not have an associated fee for health care students.

Submit a copy of the certified Student Immunization Record directly to nursing@tru.ca and not back to the Admissions Department. Ensure all dates are written and keep the original immunization record. If you are in-process of an immunization series, still submit form, then update when completed series.

For patient safety this document must be submitted before you are allowed into the practice setting

Review HealthLink BC for information on the following vaccines to understand the immunization schedule

https://www.healthlinkbc.ca/health-feature/immunizations

https://www.healthlinkbc.ca/tools-videos/bc-immunization-schedules

http://www.healthlinkbc.ca/servicesresources/healthlinkbcfiles/hlfileslist.html

The following recommended vaccines are for Health Care Workers (HCW)/students referenced from the BCCDC.

Email/scan/FAX/postal mail to:
TRU Williams Lake Campus
1250 Western Avenue,
Williams Lake, BC V2G 1H7
EMAIL: wlmain@tru.ca
FAX: 250-392-4984

TRU / TRU-OL School of Nursing Student Immunization Record

Name: ____________________ ________________ _____ Maiden Name: ________________________
(Last) (First) (Initial) (If applicable)

Date of Birth_____/____/______ Personal Health Number________________________
dd mm yr

Student ID#:___________________Program:_________________________Date of entry: __________________

TB Skin Test

All students should have a TB Skin Test unless they are a known positive reactor or unless they have documented proof of a previous negative test result within the past 6 months, prior to commencement of the program. Those with a known positive reaction in the past should have a chest x-ray unless there is proof of previous chest x-ray results within 6 months.

TB Skin Test Date**:**_____________TB Read Date:_______________Result:_______(mm)

Read By:________________________________
(Signature of Health Care Provider and agency stamp)

A Chest X-ray is required if the TB skin test is positive, or if there is a history of a previous positive reaction.

Chest X-ray Date:_______________________________ Result: ________________________________

********* List all dates for vaccines in the following order: Year/Month/Day********

1. Tdap –Tetanus / **D**iphtheria / **a**cellular **P**ertussis Vaccine

Primary Series - **T**etanus/**D**iphtheria/**P**ertussis vaccine (3 or 4 doses) in early childhood: Yes______No _____

Td Booster can be given with a Polio booster (**10 years after primary series**)___________________ (Date)

If no, completion of 3 dose series:

Tdap Dose #1 (0 month): _________________(Date)

Td Dose #2 (1 month): _________________(Date)

Td Dose #3 (6-12 months after the 2nd Dose: _________________(Date)

2. IPV – Inactivated **P**olio (Poliomyelitis) **V**accine

Primary Series (3 doses) in early childhood: Yes______No _________

Adult (> 18 years) Single Polio Booster dose 10 years after primary series for HCW/students ___________ (Date)

If no Single Polio Booster, completion of 3 dose series:

IPV Dose #1:__________________(Date)

IPV Dose #2:__________________(Date)

IPV Dose #3:__________________(Date)

3. **MMR – M**easles / **M**umps / **R**ubella

Up to 2 doses of MMR are recommended for all individuals (HCW/student) born on or after January 1, 1957 are considered to have acquired natural immunity to MMR.

MMR Vaccine #1:______________________(Date)

MMR Vaccine #2:______________________(Date)

Measles, Mumps or Rubella lab test for immunity if needed:

Specify Test____________________Result__________________________Date ____________________
Specify Test____________________Result__________________________Date ____________________
Specify Test____________________Result__________________________Date ____________________

4. Var - Varicella (Chicken Pox or Herpes zoster)

If Varicella disease history or date of vaccines cannot be confirmed, then a Varicella IgG titre (blood test) must be completed to determined immunity.

History of Disease: Yes___________No__________ Date (if known) _____________________________

OR Varicella immunity (IgG antibody) Yes___________No_______Date_____________________________

If susceptible then Varicella Vaccine: Dose #1 _________________Dose #2 _________________
(6 weeks apart) (Date) (Date)

5. HB - Hepatitis B Vaccine

Individuals 18 and 19 years of age: 3 doses **(0.5 mL each)** given at 0, 1 and 6 months
Individuals 20 years of age and older born in 1980 or later: 3 doses **(1.0 mL each)** given at 0, 1, and 6 months
Can be a 2-dose series if given in 6th grade

Hepatitis B Titres___________________________(Date)

3-dose series:
Dose #1 (0 month):____________(Date)

Dose #2 (1 month):____________(Date)

Dose #3 (6 months) ___________ (Date)

2-dose series (6th grade)
Dose #1 (0 month):____________(Date)

Dose #2 (6 month):____________(Date)

6. Annual (October to February) Influenza vaccine ______________________ (Date)

Public Health, Nurse Practitioner or Physician Certification: I certify that the above information is accurate and up-to-date.

____ ________________________________
(Signature of student) (Date)

____
(Name/Stamp of Health Care Provider reviewing this document) (Signature of Health Care Provider) (Date)

Ensure all dates are recorded and keep a copy of your immunization record:

For Educational Institution Use Only:
Date Form received:____________________In person ☐ mail ☐ fax ☐ email ☐

Data entered in computer (if applicable) by:________________________Form complete ☐