TRU/TRU-OL School of Nursing Student Immunization Record - INSTRUCTIONS

Dear TRU Nursing Student:

Immunization protects clients, health care workers and students from 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, thus impeding their success in the program. Moreover, practice facilities may not accept unvaccinated students on a unit.**

It is recommended that you start immediately, as the immunization process may take up to 6 months to complete.

All Immunizations *must be done* ***no more than 6 months prior to starting your program.***
Ensure any boosters are complete prior to starting your practicum.

1. **Have a TB skin test, as other vaccines can delay when this test can be done**
   a) See the TB Skin Test Section for more instructions.
2. **Have a Blood Test done (Titre test) to determine your immunization status**
   a) Contact a physician to obtain the lab requisition for this test.

   Locate your personal immunization records
   (Possible Sources: Immunization Childhood Booklet, Public Health Unit, Travel Clinic, Family Physician)
3. **Make an appointment with a Health care Provider**
   Public Health Unit, Primary Care Clinic, Nurse Practitioner, Travel Clinic or Family Physician. The Health Care provider will determine which immunizations you may still require based on the Titre test results and any/all immunization records.
4. **Have the health care provider complete the TRU immunization form**
   Dates, certification section and student signature are required fields.
5. **Submit a pdf, jpeg or word copy of your signed certified Student Immunization Record Form to:**

Kamloops Campus – BScN	Moodle
Open Learning	Moodle
Kamloops Campus- HCA	Moodle
Williams Lake Campus – HCA, PN, BScN	Moodle

6. **If you have any questions, please contact:**
   a. Kamloops campus- BScN students: nursingpractice@tru.ca
   b. Open Learning students: tru_ol_nursing@tru.ca
   c. Williams Lake campus students: wlnursing@tru.ca
   d. All other Kamloops campus students: nursing@tru.ca

NOTE: If you are in the process of completing the required immunizations, indicate your next appointment date(s), and provide updated form after each subsequent dose. Updating the School of Nursing is the student's responsibility.

7. **Keep a copy for your records you will require your Immunization Records to secure Employment**

In Person/Mail:
Thompson Rivers University
School of Nursing, Office NPH 242
805 TRU Way
Kamloops, BC V2C 0C8

THOMPSON RIVERS UNIVERSITY | School of Nursing

TRU/TRU-OL School of Nursing Student Immunization Record

Note: Please have a **Public Health Care Provider/Physician complete and certify** this form.
No other form/documentation will be accepted as proof of completed immunization requirements.

Last Name	First Name	Maiden Name (If applicable)	Date of Birth (dd/mm/yyyy)	myTRU E-mail Address
Personal Health Number	**TRU ID #**	**Program**	**Date of Entry**	**Phone Number**

Tetanus, Diphtheria, Pertussis (Tdap) Vaccine			
Primary series – In early childhood ☐ Yes (Provide dates to the right →)	**Dose #**	**Date** (dd/mm/yyyy)	**Health Care Provider Signature**
	Td #1		
	Td #2		
	Td #3		
☐ **If Childhood Series Complete – Date of Booster** *NOTE: Required EVERY 10 years after primary series	**Booster**		
☐ **If NO Childhood Series,** a 3 dose series is required:	**Enter dates Dose #1-3**		

Poliomyelitis - Inactivated Polio (IPV) Vaccine			
Primary Series – In early childhood? ☐ Yes (Provide dates to the right →)	**Dose #**	**Date** (dd/mm/yyyy)	**Health Care Provider Signature**
	IPV #1		
	IPV #2		
	IPV #3		
If YES, Date of Polio booster: *NOTE: ONE TIME only booster 10 years after the primary series	**Booster**		
If NO, a 3 dose series is required:	**Enter dates Dose #1-3**		

Measles/Mumps/Rubella (MMR) Vaccine ****Proof of 2 MMR REQUIRED for all Health Care Workers****			
Primary Series - ☐ Yes (Provide dates to the right →)	**Dose #**	**Date** (dd/mm/yyyy)	**Health Care Provider Signature**
	MMR #1		
	MMR #2		

Varicella (VAR) Vaccine (Chicken Pox or Herpes Zoster)			
In early childhood? ☐ Yes (Provide dates to the right →)	**Dose #**	**Date** (dd/mm/yyyy)	**Health Care Provider Signature**
	VAR #1		
History of disease – ☐ Yes ☐ No If YES, Include Date (mm/yyyy) : _____	**VAR #2**		
If NO, Varicella blood test result: ☐ Immune ☐ Not Immune			
If NOT immune, a 2 dose series is required: Provide Dates	**Enter dates Dose #1-2**		

Hepatitis B (HB) Vaccine ****A Hep B BLOOD TEST IS REQUIRED FOR PROOF OF IMMUNITY****			
Primary series -	**Dose #**	**Date** (dd/mm/yyyy)	**Health Care Provider Signature**
In early childhood? ☐ Yes (Provide dates to the right →)	**HB #1**		
	HB #2		
HB blood test result: ☐ Immune ☐Not Immune	**HB #3**		
Series required?: ☐ Yes ☐ No (Provide Dates)			

Public Health/ Nurse Practitioner/ Physician Certification: I Certify that the above information is accurate.

_____	_____	_____	_____	_____
Health Care Provider's PRINT NAME	Health Care Provider's Signature & Stamp	Date	Student's signature	Date