

Last Name		First Name		Middle Initial
Banner ID #		Birth Date (DD/MM/YY)		Phone
Mailing Address			Email	
Degree Program or Position (Check One)				
<input type="checkbox"/> Bachelor of Dental Hygiene (BDH)		<input type="checkbox"/> Qualifying Program Dentistry (QP)		
<input type="checkbox"/> Undergraduate Program Dental Hygiene (DH)		<input type="checkbox"/> Graduate Program Dentistry		
<input type="checkbox"/> Doctor in Dental Surgery (DDS)		<input type="checkbox"/> Other _____		

This section to be completed and signed by your physician:

Required Immunization	Dates Immunization Received (DD/MM/YY)			Antibody Titre Results* or Laboratory Diagnosed History of Disease	
				Date	Results
Tetanus, diphtheria, pertussis (Td/Tdap) 1 dose within past 10 years	Dose 1				
Polio (IPV) Primary Course	Dose 1				
German Measles (Rubella) 2 doses after age 12 months	Dose 1	Dose 2			
Measles (Rubeola) 2 doses after age 12 months	Dose 1	Dose 2			
Mumps 2 doses after age 12 months	Dose 1	Dose 2			
Varicella (Chicken Pox) 2 doses	Dose 1	Dose 2			
Hepatitis B or A/B Series of 3 doses*	Dose 1	Dose 2	Dose 3		
Hepatitis B Surface Antigen (HbsAg) Required if vaccine not complete					
Hepatitis B Antibodies Mandatory					
Baseline PPD (Tuberculosis Screening) 2-Step Mantoux	Step 1		Induration		
	Step 2		Induration		
Annual 1-Step Mantoux	Step 1		Induration		

If there is a documented prior positive TST, previous treatment for active TB, or previous treatment for latent TB, a TST is not required. Medical evaluation and a chest X-ray within 1 year are required.

Date of Chest X-ray: ___ / ___ / ___. Please attach copies of chest X-ray report.
DD MM YY

* Copies of antibody titre results must accompany this form.

Physician Signature: _____ Date: _____

Influenza			
Year 1	Year 2	Year 3	Year 4
CPR / AED Certification (Annual renewal is recommended). Copy of certification must accompany this form.			
Year 1	Year 2	Year 3	Year 4

Authorization for Disclosure of Information
I understand that it is my responsibility to inform the appropriate personnel of any communicable disease, special need or medical condition which may place me at a risk or pose a risk to others during clinical placements. The information on the immunization form will be kept confidential within my clinical site. However, under the following circumstances and for the duration of the program, I authorize the release of this immunization record to: 1. The clinical site personnel where an occupational exposure occurs; 2. The treating medical site/institution (if required); 3. Another clinical placement site (if requested).
_____ Signature of Student
_____ Date