DALHOUSIE UNIVERSITY

FACULTY OF DENTISTRY IMMUNIZATION RECORD (page 1)

Last Name	First Name	Middle Initial

Banner ID #	Birth Date (DD/MM/YY)	Phone

Mailing Address	Email

Degree Program or Position (Check One)

□ Bachelor of Dental Hygiene (BDH)
□ Undergraduate Program Dental Hygiene (DH)
□ Doctor in Dental Surgery (DDS)
□ Qualifying Program
□ Graduate Program Dentistry
□ Other

This section to be completed by your health care provider (see page 4 of memo):

Required Immunization	Dates Immunization Received (DD/MM/YY)			Antibodies 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 or 3 doses of Adult Series	Dose 1	Dose 2	Dose 3		
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	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		
Post-vaccination Serology Test (all applicants)* 1. Hepatitis B Surface Antibodies (anti-HBs)*				*	
Additional Post-vaccination Serology Tests (for applicants from countries endemic with HB – High & Intermediate) *Copies of antibody titer results MUST accompany this form.					
1. Hepatitis B Surface Antigen (HBsAg)					
2. Hepatitis B Core Antibodies (anti-HBc)					

*Post-serology testing for applicants born or previously residing in high HBV endemic countries must include both anti-HBc and HBsAg as well as anti-HBs to fully define HBV status before acceptance into the program. This includes applicants from all countries except for those listed as having a Low (<1%) incidence of Hepatitis B (Appendix A).

FACULTY OF DENTISTRY IMMUNIZATION RECORD (page 2)		
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.
Day Month Year

Healthcare Provider Name (please print):_____

Signature: _____ Date: _____

CPR-HCP (Health Care Provider) Certification (Annual renewal is required). *Copy of certification must accompany this form.*

Date (MM/YYYY)	

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 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 occupational exposure occurs; 2. The treating medical site/institution (if required); 3. Clinical placement sites (if requested).

Name of Student (Please print):_____ Signature of Student: _____

_____
Date

Revised: July 2024 /Clinical/Admin/Forms/Infectious Disease Policies & Immunization

Return Completed form to:

Clinical Nurse, Faculty of Dentistry, Dalhousie University
5981 University Avenue,
Halifax,
NS B3H 4R2
Canada

Forms may also be emailed to tanya.aquino@dal.ca or faxed to 902-494-1757.

For questions regarding this form, please call Ms. Tanya Aquino @ 902-494-1673.