

<b>Last Name</b>		<b>First Name</b>		<b>Middle Initial</b>
<b>Banner ID #</b>		<b>Birth Date (DD/MM/YY)</b>		<b>Phone</b>
<b>Mailing Address</b>			<b>Email</b>	
<b>Degree Program or Position (Check One)</b>				
<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			
<b>Tetanus, diphtheria, pertussis (Td/Tdap)</b> 1 dose within past 10 years	Dose 1				
<b>Polio (IPV)</b> Primary Course	Dose 1				
<b>German Measles (Rubella)</b> 2 doses after age 12 months	Dose 1	Dose 2			
<b>Measles (Rubeola)</b> 2 doses after age 12 months	Dose 1	Dose 2			
<b>Mumps</b> 2 doses after age 12 months	Dose 1	Dose 2			
<b>Varicella (Chicken Pox)</b> 2 doses	Dose 1	Dose 2			
<b>Hepatitis B or A/B</b> Series of 3 doses*	Dose 1	Dose 2	Dose 3		
<b>Mandatory Post vaccination Serology Tests</b>					
<b>1. Hepatitis B Surface Antigen (HbsAg)</b>					
<b>2. Hepatitis B Surface Antibodies (anti-HBs)</b>					
<b>Baseline PPD (Tuberculosis Screening) 2-Step Mantoux</b>	Step 1		Induration		
	Step 2		Induration		
<b>Annual 1-Step Mantoux</b>	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: \_\_\_\_\_

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

<b>Authorization for Disclosure of Information</b>	
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

Return Completed form to: Clinical Nurse, Faculty of Dentistry  
Dalhousie University • 1459 Oxford Street • Halifax NS B3H 4R2 Canada. Forms may also be faxed to 902-494-1757.  
For questions regarding this form, please call Ms. Sue Murphy @ 902-494-1673.