DALHOUSIE UNIVERSITY
Inspiring Minds

FACULTY OF DENTISTRY
IMMUNIZATION/CPR RECORD

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 Dentistry (QP)
- ☐ Graduate Program Dentistry
- ☐ 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

Return Completed form to: Infection Control Officer, 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. Cathy MacLean @ 902-494-1673.

Revised: 09.23.13