Last Name | First Name | Salutation | Changed | Save | C

Address 1
Address 2
City: Edmonton | Prov: AB
Postal | Country: Canada
Email | + | Send
Quick Code

Phone Numbers (0) F2 Ins Del

Description	Phone

Family Doctor | F2 | Clear

Birthdate
Age
Gender: Male Female
Language
Height | +
Weight | +

Load | Dele

Comments (0) F2 Ins Del

Topic	Comment
Program:	

Student ID:

PHN

Plans (0) F2

SubPlan Code	Group ID	Client ID	Expiry

Student Name: _____

2024-2025 HEALTH FACULTY IMMUNIZATION CLEARANCE FORM

Student Name:

Student ID Number:

Date of Birth:

Country of Birth:

Program:

UNIVERSITY OF ALBERTA
UNIVERSITY HEALTH CENTRE

* COPIES OF ALL ORIGINAL & NEW IMMUNIZATION RECORDS AND TEST RESULTS MUST BE SUBMITTED WITH THIS FORM.

** A minimum of a month and year is REQUIRED for a vaccine dose to be considered valid.

*** Submitting pending & completed copies of this form (& attachments) to the faculty is the responsibility of the student. The UHC cannot legally release this information to the faculty on your behalf as a result of the Health Information Act (HIA)

**** "It is the responsibility of the Health Care Student and students in other High-Risk Programs to initiate and follow through with the assessment of their immunization status with their occupational health or student health services program (Alberta Health Services. (2022). *Immunization Recommended for Health Care Students and Students in Other High-Risk Occupational Programs.*
https://www.albertahealthservices.ca/assets/info/hp/cdc/if-hp-cdc-ipsm-imm-recomm-hcs-high-risk-occ-prg-appdx-a-08-302.pdf)

VACCINE	AHS GUIDELINE	RESULTS:
TETANUS, DIPHTHERIA, PERTUSSIS	• All students must have a primary series of 3 or more documented doses of tetanus/diphtheria containing vaccine, including a reinforcing dose within the last 10 years. • **All students must have documentation of a dose of acellular pertussis containing vaccine (Ex. Tdap) *on/after the age of 18* - Regardless of when the most recent dose of tetanus was.** • If the student has no documentation – complete a primary series of 3 doses of tetanus, diphtheria, pertussis at the appropriate intervals.	Document the **last three** tetanus, diphtheria, pertussis containing immunizations: Dose #1: _____ Dose #2: _____ Dose #3: _____ ***Most recent dose: for most students this will be the adult Tdap at >18 yrs. If the most recent dose was administered when the student was <18 years of age, the form will be considered incomplete.*** **The most recent dose must be within the last 10 years**

POLIO	• All students must have a primary series of 3 or more documented doses of polio-containing vaccine with at least 1 dose administered after the age of 4 years. **AND** • **All students must also have documentation of a single lifetime reinforcing dose of polio-containing vaccine *on/after the age of 18*.** *This dose should be administered at least 10 years after the completion of the primary series.* • If the student has no documentation – complete a primary series of 3 doses of polio-containing vaccine at the appropriate intervals.	Document the **last three** polio containing vaccine doses: Dose #1: _____ Dose #2: _____ Dose #3 (>4 years of age): _____ **AND** ☐ Date of one time ADULT BOOSTER (>18 years of age) dose if 10 or more years since last dose: _____ **OR** ☐ Booster not applicable as <10 years since last dose.
TUBERCULOSIS TESTING (TST)	• 1-step TST result **in millimeters (mm)** within **12 months** of the program start date. • BCG vaccination is **NOT** a contraindication to a TST. • A Chest X-Ray without written documentation of a positive TST in millimeters will **NOT** be accepted. • If there is documentation of a previously positive TST in millimeters – only a Chest X-Ray is required within **6 months** of the program start date. *REPORT MUST BE ATTACHED.	Date of TST: _____ Date of Reading: _____ Result: _____ mm **Chest X-Ray:** (**Required** if current TST is positive or there is a history of a positive TST) Date: _____ Result: ☐ NORMAL ☐ ABNORMAL ☐ NOT APPLICABLE Referral to **TB Services**? ☐ YES ☐ NO
VARICELLA (Chicken Pox)	• 2 doses of varicella-containing vaccine after 12 months of age at appropriate intervals. Students who have 1 dose of varicella-containing vaccine should be offered a second dose. **OR** • POSITIVE Varicella IgG serology results. • If Varicella IgG results are negative or indeterminate - Vaccination is required. Adults need 2 doses with a minimum interval of 6 weeks between doses. ***Serology after vaccination is not recommended.**	Dose #1: _____ Dose #2: _____ **OR** **Varicella Serology**: COPY OF LAB RESULT MUST BE ATTACHED TO THIS FORM Date: _____ Result ☐ POSITIVE ☐ NEGATIVE / INDETERMINATE ☐ NOT APPLICABLE

MEASLES, MUMPS & RUBELLA	• 2 valid doses of measles-containing vaccine after 12 months of age. • 2 valid doses of mumps-containing vaccine after 12 months of age. • 1 valid dose of rubella-containing vaccine after 12 months of age is legislated under the Alberta Public Health Act.	**MMR:** Dose #1: _____ Dose #2: _____ **OR** **Measles:** Dose #1: _____ Dose #2: _____ **Mumps:** Dose #1: _____ Dose #2: _____ **Rubella:** Dose #1: _____
HEPATITIS B VACCINATION	Serological testing in the absence of immunization records **will NOT** be accepted. • All students must have documentation of a complete Hepatitis B immunization series. • An acceptable primary series can be 2-4 doses depending on the age and geographic area in which it was administered. • **Positive serology (Anti-HBs) will NOT be accepted if there is an incomplete or absent record of immunization, unless the student has serology that indicates previous infection.**	Dose #1: _____ Dose #4: _____ Dose #2: _____ Dose #5: _____ Dose #3: _____ Dose #6: _____ Dose #7: _____
HEPATITIS B BLOOD TESTING	The Hepatitis B serology recommendations for health care students differ based on the students' risk of past Hepatitis B infection. ***Not at risk of past infection*:** A Hepatitis B Surface Antibody (Anti-HBs) is required ***At risk of past infection*:** A Hepatitis B Surface Antibody (Anti-HBs), Hepatitis B Core Antibody (Anti-HBc), & Hepatitis B Antigen (HBsAg) are required. ***(High Risk:** Students who have immigrated to Canada from a Hepatitis B endemic country (see Appendix A), those who have received repeated blood transfusions, those with a history of dialysis, and those with lifestyle risks of infection, etc.)*	***Please check one:*** ☐ **Student is NOT AT RISK of past infection** (*The student's country of origin is NOT a Hepatitis B endemic country & they do NOT have a history of risk factors*). **OR** ☐ **Student is AT HIGH RISK of past infection**

	• A student with a POSITIVE Anti-HBc (core) and/or HBsAg requires a physician letter explaining the results. • If a student has low Anti-HBs of less than 10u/L, the student will need to receive boosters (at the appropriate intervals) as per the attached *AHS Hepatitis B Algorithms (Appendix B &C)* until a positive Anti-HBs of 10u/L or greater, is achieved. • If a student has received a total of 2 complete series of the hepatitis B vaccine and their Anti-HBs remain low (<10 u/L), the student is considered a non-responder, and no further hepatitis B vaccination is recommended. The student will then need to have an HBsAg completed (regardless of risk) and will require a letter stating they are a non-responder from a physician.	**Mandatory Serology:** *Required for all students* **Anti-HBs:** Date: _____ Result: _____ U/L Interpretation: ☐ POSITIVE ☐ NEGATIVE • COPY OF LAB RESULT MUST BE ATTACHED TO THIS FORM **If required (*High- Risk Students only*):** **Anti-HBc (core):** *Required for those students at high risk of past Hepatitis B infection* Date: _____ Result: ☐ POSITIVE ☐ NEGATIVE ☐ NOT APPLICABLE • COPY OF LAB RESULT MUST BE ATTACHED TO THIS FORM **HBsAg:** *Required for those students at high-risk of past Hepatitis B infection or those considered non-responders to Hepatitis B immunization* Date: _____ Result: ☐ POSITIVE ☐ NEGATIVE ☐ NOT APPLICABLE • COPY OF LAB RESULT MUST BE ATTACHED TO THIS FORM **Letter from physician explaining results:** *Required for students who have a positive Anti-HBc, a positive HBsAg or a student who is considered a non-responder to Hepatitis B immunization* ☐ Letter attached
SEASONAL INFLUENZA	• **Recommended for ALL Health Care Students.**	1 dose annually.

Clinic Stamp:

_____ _____ _____

Health Care Provider Name **Health Care Provider Signature** **Date**

TB Mantoux Skin Test Intake Form

First Name: _____ **Last Name:** _____ **Date:** _____

Cell Phone Number: _____ **DOB:** _____ **AHC #:** _____

Address: _____ **City** Edmonton **Prov:** AB

Emergency Contact Name & Phone Number: _____

Do you take any medications: _____

Allergies: _____ **Email:** _____

Check all that apply:

- ☐ Coughing for three or more weeks
- ☐ Coughing up blood or mucus
- ☐ Chest pain, or pain with breathing or coughing
- ☐ Unintentional weight loss
- ☐ Fatigue
- ☐ Fever, Night sweats or Chills
- ☐ Loss of appetite
- ☐ Live or are from a country where TB is common (Latin America, Africa and Asia)
- ☐ In contract with people who have TB or treat people with high risk.
- ☐ Have had the BCG (Bacille Calmette-Guerin vaccine) vaccine, sarcoidosis, or Hodgkin's lymphoma
- ☐ Have HIV/AIDs or a positive test result before
- ☐ Have had one or more of the following vaccines in the past 4 weeks: four weeks AFTER a Covid, MMR or Chickenpox vaccine
- ☐ None of the above

I consent to having a Mantoux Tuberculin Skin Test (TST) done, to wait 15 minutes after so that any allergic reactions can be monitored, & agree to having my personal health information shared with public health officials and other healthcare providers. *

- ○ Yes, I consent Signature:
- ○ No

I understand that I am responsible for booking a follow up appointment within 48 – 72 hours following my test. If I do not then the test must be repeated. *

- ○ Yes, I agree Signature: _____
- ○ No

OFFICE USE ONLY

Test Date:_____ Reading Date:_____

Time: READING Time:

TUBERSOL (DIN:00317268) – Sanofi Pasteur Reading: _____mm

LOT:_____

EXPIRY:_____ Initial: _____

Initial: _____Site: Right/Left Forearm

GENERAL LABORATORY REQUISITION

DynaLIFE MEDICAL LABS

Appointment Booking & Locations: www.dynalife.ca or www.albertaprecisionlabs.ca
Access to Test Results: www.alberta.ca/mhr
*Dyna***LIFE** Medical Labs: **1 (800) 661-9876** or **(780) 451-3702**
Alberta Precision Laboratories: **1 (877) 868-6848**

Scanning Label or Accession # *(lab only)*

Patient

PHN / Healthcare Number Expiry:_____ | Alternate Identifier
Legal Last Name | Legal First Name | Middle Name | Date of Birth *(dd-Mon-yyyy)*
Preferred Name | ☐ Male ☐ Female ☐ X (Non-Binary/Prefer not to Disclose) | Phone
Address | City / Town: Edmonton | Province: AB | Postal Code

Provider(s)

Authorizing Provider Name *(Last, First, Middle)*: Manhas, Raj
Address: 10382 105 ST NW, EDMONTON T5J 1E6
CC Provider ID: 2866 | CC Submitter ID: 12047 | Legacy ID
Clinic / Building Name: Central Point Pharmacy

Copy To 1

Authorizing Provider Name *(Last, First, Middle)*
Address
Phone
Clinic / Building Name

Copy To 2

Authorizing Provider Name *(Last, First, Middle)*
Address
Phone
Clinic / Building Name

Collection

Date *(dd-Mon-yyyy)* | Time *(24h)* | Location | Collector ID

☐ Routine ☐ Stat | Requisition Date

***F** Denotes a **fasting test**
***I** Special instructions, see website

Hours Fasting _____

☐ Third Party Bill? Client _____

Hematology / Coagulation

☐ CBC and Differential ☐ CBC no Differential
☐ D-dimer
☐ Fibrinogen
☐ INR
☐ Reticulocyte Count

General Chemistry

☐ Albumin
☐ Alkaline Phosphatase (ALP)
☐ Alanine Aminotransferase (ALT)
Bilirubin: ☐ Total ☐ Total and Conjugated
☐ Calcium
☐ C-Reactive Protein (CRP)
☐ Creatine Kinase (CK)
☐ Creatinine (eGFR)
Electrolytes: ☐ Sodium ☐ Potassium
☐ Ferritin
☐ Gamma Glutamyl Transferase (GGT)
☐ Glucose Fasting ***F** ***I**
☐ Glucose Random
☐ Hemoglobin A1c
☐ HCG, Serum (Quantitative)
Immunoglobulins: ☐ A (IgA) ☐ G (IgG) ☐ M (IgM)
☐ Lipase
☐ Magnesium
☐ Phosphate
☐ Prostate Specific Antigen (PSA)
☐ Protein Electrophoresis-Serum
☐ Total Protein
☐ Urate

☐ Lipid Panel ☐ Cholesterol ☐ Triglycerides
☐ Cardiovascular Disease Risk Assessment *(includes Lipid Panel)*

Required History:

Systolic Blood Pressure (mmHg) _____
Tobacco Use ☐ Yes ☐ No
Treated for High blood pressure ☐ Yes ☐ No
Diabetic ☐ Yes ☐ No
Chronic Kidney Disease ☐ Yes ☐ No
Atherosclerosis ☐ Yes ☐ No
First Degree Relative with CVD (M<55Y / F<65Y) ☐ Yes ☐ No

Glucose Tolerance Tests

☐ Glucose, Gestational Diabetes Screen (GDS)
☐ Glucose Tolerance, Gestational, 2h ***F** ***I**
☐ Glucose Tolerance, 2h ***F** ***I**

Miscellaneous

☐ FIT Colorectal Cancer Screening (Age 50-74) ***I**
☐ H. pylori ***I**
☐ Hemoglobinopathy Investigation

Endocrinology

Cortisol:
☐ Random ☐ AM (0700-1000) ☐ PM (1500-1800)
☐ Estradiol
☐ Follicle Stimulating Hormone (FSH)
☐ Luteinizing Hormone (LH)
☐ Parathyroid Hormone (PTH)
☐ Progesterone
☐ Prolactin
☐ Testosterone, Total
☐ Thyroid Stimulating Hormone (TSH)
☐ Thyroid Stimulating Hormone (TSH), Progressive

Immunology / Serology

☐ Epstein - Barr Virus Serology - IgM
☐ Hepatitis A Virus Acute Serology - IgM
☐ Hepatitis A Virus Immunity Serology - IgG
☒ Hepatitis B Surface Antigen
☒ Hepatitis B Surface Antibody
☐ Hepatitis C Virus Serology
☐ HIV 1 and 2 Serology (Antigen and Antibody)
☐ Mononucleosis Screen
☐ Rheumatoid Factor
☐ Rubella Immunity Serology - IgG
☐ Syphilis

Cardiology

☐ Electrocardiogram
ECG to be read by:
☐ DynaLIFE Panel ☐ Other _____

Transfusion Medicine

☐ Direct Antiglobulin Test (DAT)
☐ RHIG Eligibility, Prenatal
Type & Screen - separate process required, contact lab
Prenatal Type & Screen - use CBS Perinatal Requisition

Sterile Body Fluid

☐ Fluid Type _____ Source _____
Test(s) _____

Urine

☐ Urinalysis

Albumin (Creatinine Ratio) ☐ Random ☐ 24h
Creatinine ☐ Random ☐ 24h
Cortisol ☐ 24h
Protein Electrophoresis ☐ Random ☐ 24h
Total Protein (Creatinine Ratio) ☐ Random ☐ 24h
☐ Creatinine Clearance 24h Ht ____ cm Wt ____ kg

24h Urine ***I***

Total Volume _____
Start Date _____ Start Time _____
End Date _____ End Time _____

Clinical Information

Drug Levels / Monitoring

☐ Ethanol Level, Blood

Therapeutic Drug Monitoring:

Dose Route ☐ Oral ☐ IV ☐ Other
Dose Regimen _____
How Long on Current Regimen? _____
Date of Last Dose or IV Complete _____
Time of Last Dose or IV Complete _____
Date of Next Dose or IV Start _____
Time of Next Dose or IV Start _____
☐ Carbamazepine ☐ Phenytoin, Total
☐ Cyclosporine Pre Dose ☐ Sirolimus
☐ Cyclosporine 2h Post ☐ Tacrolimus
☐ Digoxin ☐ Theophylline
☐ Lithium ☐ Valproate
☐ Phenobarbital ☐ Other _____

Antibiotics:

Gentamicin ☐ Pre ☐ Post ☐ Interval ☐ Other
Tobramycin ☐ Pre ☐ Post ☐ Interval ☐ Other
Vancomycin ☐ Pre ☐ Other

Urine Drug Testing Panels

Reason for Request _____
☐ Opioid Dependency Panel
What is the Treatment Regimen?
☐ Buprenorphine ☐ Methadone
☐ Morphine ☐ Hydromorphone
☐ Other _____
OR
☐ General Toxicology Panel

Chlamydia / Gonorrhea / Trichomonas

☐ Chlamydia & Gonorrhea Screen ☐ Prenatal Screen
☐ Vagina[1]
☐ Endocervical[2]
☐ Urine, First Catch[3]
☐ Urethra[2] ☐ Rectal[1]
☐ Throat[1] ☐ Eye[1]

Transport Device:
[1] Aptima Multitest swab (Orange label, PINK shaft)
[2] Aptima Unisex swab (White label, BLUE shaft)
[3] Aptima Urine Collection kit (Yellow label)

☐ Trichomonas Vaginalis Screen
Female ≥ 14Y:
☐ Vagina[1] ☐ Endocervical[2] ☐ Urine, First Catch[3]

Additional Tests

VZV IgG
anti-HBc total

CENTRALPOINT PHARMACY

Immunization Record

Central Point Pharmacy, 10382-105 Street NW, Edmonton AB T5J 1E6
Phone: (780) 250-2616 Fax: (780) 250-2617

PATIENT INFORMATION

First Name	*Last Name*	*Gender*	*DOB*	*Weight*
Address Edmonton		*Health Card #*		*Phone Number*
Emergency Contact	*Relationship to Patient*	*Contact's Phone Number*		*Contact's Other Phone Number*

SCREENING QUESTIONNAIRE

Are you experiencing any cold, flu or COVID-19-like symptoms, even mild ones?		*Yes*	*No*	*Unsure*
Have you travelled to any countries outside Canada (including the United States) within the last 14 days?		*Yes*	*No*	*Unsure*
Did you provide care or have close contact with a person with confirmed COVID-19?		*Yes*	*No*	*Unsure*
Are you allergic to any medications including vaccines?		*Yes*	*No*	*Unsure*
Do you have an allergy to kanamycin, neomycin, gentamicin, thimerosal, chicken protein, polymixin or gelatin?		*Yes*	*No*	*Unsure*
Have you ever had a severe, life threatening reaction to a past vaccination?		*Yes*	*No*	*Unsure*
Have you had wheezing, chest tightness or difficulty breathing within 24 hours of getting a vaccine?		*Yes*	*No*	*Unsure*
Are you allergic to latex gloves?		*Yes*	*No*	*Unsure*
Have you had Guillain-Barre Syndrome within 6 weeks of getting a vaccine?		*Yes*	*No*	*Unsure*
Do you have a new or changing neurological disorder?		*Yes*	*No*	*Unsure*
Do you take a blood thinner or have a bleeding disorder?		*Yes*	*No*	*Unsure*
Pharmacist-Will you be administering a Live Vaccine? *(If "No", skip the following questions)*		*Yes*	*No*	
Do you have a medical condition that can weaken your immune system? (eg. Leukemia, Lymphoma, HIV/AIDs)		*Yes*	*No*	*Unsure*
Are you taking any medications that can weaken your immune system within the past 3 months? (eg Prednisone etc)		*Yes*	*No*	*Unsure*
Have you received any other vaccines in the last 4 weeks?		*Yes*	*No*	*Unsure*
Are you or do you think you might be pregnant?	*N/A*	*Yes*	*No*	*Unsure*

CONSENT GIVEN BY PATIENT/AGENT

I, the undersigned client, parent or guardian, have read or had explained to me, information about the vaccine as outlined in the vaccine information sheets provided to me. I have had the chance to ask questions, and answers were given to my satisfaction. I agree to wait in the pharmacy for 15 minutes(or time recommended by the pharmacist) after getting the vaccine. I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and is a medical emergency. If I experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 9-1-1 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

☐ I confirm that I want to receive OR ☐ I confirm that I want my child to receive

_____Product_____

Patient/Agent & Relationship	*Patient/Agent Signature*	*Date Signed*

PHARMACIST DECLARATION I confirm the above named patient is capable of providing consent for _____Product_____ and that the _____Product_____ should be given to patient.

Pharmacist	*Pharmacist Signature*	*Date Signed*

Prescription Authorization

Patient:
Address: Edmonton
DOB:
Phone:

Engerix-B 20mcg/mL
Generic Name: Hepatitis B Surface Antigen (Recombinant) Disp Qty 1
DIN 02487039 INJECT 1ML INTRAMUSCULARLY (0,1,6 MONTHS)
Approved Qty 1
Repeats 2

MMR II Vaccine 0.5ml
Generic Name: Measles/Mumps/Rubella Virus Vaccine Disp Qty 1
DIN 00466085 INJECT 0.5 ML(S) SUBCUTANEOUSLY (0,28 DAYS)
Approved Qty 1
Repeats 1

Varivax III 1350 Unit/0.5mL
Generic Name: Varicella-Zoster Virus Vaccine Disp Qty 1
DIN 02246081 INJECT 0.5ML SUBCUTANEOUSLY (0, 3 MONTHS)
Approved Qty 1
Repeats 1

Boostrix Publicly Funded
Generic Name: Publicly Funded Tdap Vaccine
DIN 02247600 INJECT 0.5 MLS INTRA MUSCULAR
Approved Qty 1
Repeats

Prescriber Name (print name) Raj Manhas ID # 14127

Prescriber Signature _____ Date _____

Central Point Pharmacy 10382-105 Street NW Edmonton AB T5J 1E6
Tel: (780) 250-2616 Fax: (780) 250-2617