

Last Name

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Topic	Comment
Program:	
Student ID:	

Plans (0)

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SubPlan Code	Group ID	Client ID	Expiry

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-ipism-imm-recomm-hcs-high-risk-occ-prg-appdx-a-08-302.pdf>)

VACCINE	AHS GUIDELINE	RESULTS:
TETANUS, DIPHTHERIA, PERTUSSIS	<ul style="list-style-type: none"> 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) <u>on/after the age of 18</u> - 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. 	<p>Document the <u>last three</u> tetanus, diphtheria, pertussis containing immunizations:</p> <p>Dose #1: _____</p> <p>Dose #2: _____</p> <p>Dose #3: _____</p> <p><i>Most recent dose: for most students this will be the <u>adult Tdap at >18 yrs</u>. If the most recent dose was administered when the student was <18 years of age, the form will be considered incomplete.</i></p> <p><i>*The most recent dose must be within the last 10 years*</i></p>

POLIO	<ul style="list-style-type: none"> 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. <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> All students must also have documentation of a single lifetime reinforcing dose of polio-containing vaccine <u>on/after the age of 18.</u> <i>This dose should be administered at least 10 years after the completion of the primary series.</i> If the student has no documentation – complete a primary series of 3 doses of polio-containing vaccine at the appropriate intervals. 	<p>Document the <u>last three</u> polio containing vaccine doses:</p> <p>Dose #1: _____</p> <p>Dose #2: _____</p> <p>Dose #3 (>4 years of age): _____</p> <p><u>AND</u></p> <p><input type="checkbox"/> Date of one time ADULT BOOSTER (>18 years of age) dose if 10 or more years since last dose: _____</p> <p><u>OR</u></p> <p><input type="checkbox"/> Booster not applicable as <10 years since last dose.</p>
TUBERCULOSIS TESTING (TST)	<ul style="list-style-type: none"> 1-step TST result <u>in millimeters (mm)</u> 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. 	<p>Date of TST: _____</p> <p>Date of Reading: _____ Result: _____ mm</p> <p><u>Chest X-Ray:</u> (Required if current TST is positive or there is a history of a positive TST)</p> <p>Date: _____</p> <p>Result: <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> NOT APPLICABLE</p> <p>Referral to TB Services? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
VARICELLA (Chicken Pox)	<ul style="list-style-type: none"> 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. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> 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. <p>*Serology after vaccination is <u>not recommended.</u></p>	<p>Dose #1: _____</p> <p>Dose #2: _____</p> <p>OR</p> <p><u>Varicella Serology:</u> COPY OF LAB RESULT <u>MUST</u> BE ATTACHED TO THIS FORM</p> <p>Date: _____</p> <p>Result: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE / INDETERMINATE <input type="checkbox"/> NOT APPLICABLE</p>

MEASLES, MUMPS & RUBELLA	<ul style="list-style-type: none"> • 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	<p>Serological testing in the <u>absence of immunization records</u> will NOT be accepted.</p> <ul style="list-style-type: none"> • 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 <u>incomplete or absent record of immunization</u>, 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	<p>The Hepatitis B serology recommendations for health care students differ based on the students' risk of past Hepatitis B infection.</p> <p><u>Not at risk of past infection:</u> A Hepatitis B Surface Antibody (Anti-HBs) is required</p> <p><u>At risk of past infection:</u> A Hepatitis B Surface Antibody (Anti-HBs), Hepatitis B Core Antibody (Anti-HBc), & Hepatitis B Antigen (HBsAg) are required.</p> <p><i>(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.)</i></p>	<p>Please check one:</p> <p><input type="checkbox"/> Student is <u>NOT AT RISK</u> of past infection (<i>The student's country of origin is <u>NOT</u> a Hepatitis B endemic country & they do <u>NOT</u> have a history of risk factors</i>).</p> <p>OR</p> <p><input type="checkbox"/> Student is <u>AT HIGH RISK</u> of past infection</p>

	<ul style="list-style-type: none"> • 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 <i>AHS Hepatitis B Algorithms (Appendix B & C)</i> 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. 	<p>Mandatory Serology: <i>Required for <u>all students</u></i></p> <p>Anti-HBs:</p> <p>Date: _____</p> <p>Result: _____ U/L Interpretation: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE</p> <ul style="list-style-type: none"> • COPY OF LAB RESULT <u>MUST</u> BE ATTACHED TO THIS FORM <p>If required (<u>High- Risk Students only</u>):</p> <p>Anti-HBc (core): <i>Required for those students at high risk of past Hepatitis B infection</i></p> <p>Date: _____</p> <p>Result: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> NOT APPLICABLE</p> <ul style="list-style-type: none"> • COPY OF LAB RESULT MUST BE ATTACHED TO THIS FORM <p>HBsAg: <i>Required for those students at high-risk of past Hepatitis B infection or those considered non-responders to Hepatitis B immunization</i></p> <p>Date: _____</p> <p>Result: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> NOT APPLICABLE</p> <ul style="list-style-type: none"> • COPY OF LAB RESULT MUST BE ATTACHED TO THIS FORM <p>Letter from physician explaining results: <i>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</i></p> <p><input type="checkbox"/> Letter attached</p>
SEASONAL INFLUENZA	<ul style="list-style-type: none"> • Recommended for ALL Health Care Students. 	1 dose annually.

Clinic Stamp:

Health Care Provider Name_____
Health Care Provider Signature_____
Date

Patient	PHN / Healthcare Number		Expiry: _____		Alternate Identifier	
	Legal Last Name		Legal First Name		Middle Name	Date of Birth (dd-Mon-yyyy)
	Preferred Name		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X (Non-Binary/Prefer not to Disclose)			Phone
	Address		City / Town		Province	Postal Code
Provider(s)	Authorizing Provider Name (Last, First, Middle)		Address		Phone	
	Address		Phone		Clinic / Building Name	
	CC Provider ID	CC Submitter ID	Legacy ID			
	Clinic / Building Name		Clinic / Building Name		Clinic / Building Name	
Collection		Date (dd-Mon-yyyy)		Time (24h)		Location
<input type="checkbox"/> Routine <input type="checkbox"/> Stat		Requisition Date		*F Denotes a fasting test *I Special instructions, see website		Hours Fasting _____ <input type="checkbox"/> Third Party Bill? Client _____
Hematology / Coagulation		Endocrinology		Clinical Information		
<input type="checkbox"/> CBC and Differential <input type="checkbox"/> CBC no Differential <input type="checkbox"/> D-dimer <input type="checkbox"/> Fibrinogen <input type="checkbox"/> INR <input type="checkbox"/> Reticulocyte Count		Cortisol: <input type="checkbox"/> Random <input type="checkbox"/> AM (0700-1000) <input type="checkbox"/> PM (1500-1800) <input type="checkbox"/> Estradiol <input type="checkbox"/> Follicle Stimulating Hormone (FSH) <input type="checkbox"/> Luteinizing Hormone (LH) <input type="checkbox"/> Parathyroid Hormone (PTH) <input type="checkbox"/> Progesterone <input type="checkbox"/> Prolactin <input type="checkbox"/> Testosterone, Total <input type="checkbox"/> Thyroid Stimulating Hormone (TSH) <input type="checkbox"/> Thyroid Stimulating Hormone (TSH), Progressive		Drug Levels / Monitoring <input type="checkbox"/> Ethanol Level, Blood Therapeutic Drug Monitoring: Dose Route <input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> 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 _____ <input type="checkbox"/> Carbamazepine <input type="checkbox"/> Phenytoin, Total <input type="checkbox"/> Cyclosporine Pre Dose <input type="checkbox"/> Sirolimus <input type="checkbox"/> Cyclosporine 2h Post <input type="checkbox"/> Tacrolimus <input type="checkbox"/> Digoxin <input type="checkbox"/> Theophylline <input type="checkbox"/> Lithium <input type="checkbox"/> Valproate <input type="checkbox"/> Phenobarbital <input type="checkbox"/> Other _____		
General Chemistry		Immunology / Serology		Antibiotics:		
<input type="checkbox"/> Albumin <input type="checkbox"/> Alkaline Phosphatase (ALP) <input type="checkbox"/> Alanine Aminotransferase (ALT) Bilirubin: <input type="checkbox"/> Total <input type="checkbox"/> Total and Conjugated <input type="checkbox"/> Calcium <input type="checkbox"/> C-Reactive Protein (CRP) <input type="checkbox"/> Creatine Kinase (CK) <input type="checkbox"/> Creatinine (eGFR) Electrolytes: <input type="checkbox"/> Sodium <input type="checkbox"/> Potassium <input type="checkbox"/> Ferritin <input type="checkbox"/> Gamma Glutamyl Transferase (GGT) <input type="checkbox"/> Glucose Fasting *F *I <input type="checkbox"/> Glucose Random <input type="checkbox"/> Hemoglobin A1c <input type="checkbox"/> HCG, Serum (Quantitative) Immunoglobulins: <input type="checkbox"/> A (IgA) <input type="checkbox"/> G (IgG) <input type="checkbox"/> M (IgM) <input type="checkbox"/> Lipase <input type="checkbox"/> Magnesium <input type="checkbox"/> Phosphate <input type="checkbox"/> Prostate Specific Antigen (PSA) <input type="checkbox"/> Protein Electrophoresis-Serum <input type="checkbox"/> Total Protein <input type="checkbox"/> Urate		<input type="checkbox"/> Epstein - Barr Virus Serology - IgM <input type="checkbox"/> Hepatitis A Virus Acute Serology - IgM <input type="checkbox"/> Hepatitis A Virus Immunity Serology - IgG <input type="checkbox"/> Hepatitis B Surface Antigen <input type="checkbox"/> Hepatitis B Surface Antibody <input type="checkbox"/> Hepatitis C Virus Serology <input type="checkbox"/> HIV 1 and 2 Serology (Antigen and Antibody) <input type="checkbox"/> Mononucleosis Screen <input type="checkbox"/> Rheumatoid Factor <input type="checkbox"/> Rubella Immunity Serology - IgG <input type="checkbox"/> Syphilis		Gentamicin <input type="checkbox"/> Pre <input type="checkbox"/> Post <input type="checkbox"/> Interval <input type="checkbox"/> Other Tobramycin <input type="checkbox"/> Pre <input type="checkbox"/> Post <input type="checkbox"/> Interval <input type="checkbox"/> Other Vancomycin <input type="checkbox"/> Pre <input type="checkbox"/> Other		
<input type="checkbox"/> Lipid Panel <input type="checkbox"/> Cholesterol <input type="checkbox"/> Triglycerides <input type="checkbox"/> Cardiovascular Disease Risk Assessment (includes Lipid Panel) Required History: Systolic Blood Pressure (mmHg) _____ Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No Treated for High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Atherosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No First Degree Relative with CVD (M<55Y / F<65Y) <input type="checkbox"/> Yes <input type="checkbox"/> No		Cardiology		Urine Drug Testing Panels		
Glucose Tolerance Tests		Transfusion Medicine		Reason for Request _____		
<input type="checkbox"/> Glucose, Gestational Diabetes Screen (GDS) <input type="checkbox"/> Glucose Tolerance, Gestational, 2h *F *I <input type="checkbox"/> Glucose Tolerance, 2h *F *I		<input type="checkbox"/> Direct Antiglobulin Test (DAT) <input type="checkbox"/> RHIG Eligibility, Prenatal Type & Screen - separate process required, contact lab Prenatal Type & Screen - use CBS Perinatal Requisition		<input type="checkbox"/> Opioid Dependency Panel What is the Treatment Regimen? <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Methadone <input type="checkbox"/> Morphine <input type="checkbox"/> Hydromorphone <input type="checkbox"/> Other _____		
Miscellaneous		Sterile Body Fluid		OR		
<input type="checkbox"/> FIT Colorectal Cancer Screening (Age 50-74) *I <input type="checkbox"/> H. pylori *I <input type="checkbox"/> Hemoglobinopathy Investigation		<input type="checkbox"/> Fluid Type _____ Source _____ Test(s) _____ Urine <input type="checkbox"/> Urinalysis Albumin (Creatinine Ratio) <input type="checkbox"/> Random <input type="checkbox"/> 24h Creatinine <input type="checkbox"/> Random <input type="checkbox"/> 24h Cortisol <input type="checkbox"/> Random <input type="checkbox"/> 24h Protein Electrophoresis <input type="checkbox"/> Random <input type="checkbox"/> 24h Total Protein (Creatinine Ratio) <input type="checkbox"/> Random <input type="checkbox"/> 24h <input type="checkbox"/> Creatinine Clearance 24h Ht _____ cm Wt _____ kg 24h Urine *I Total Volume _____ Start Date _____ Start Time _____ End Date _____ End Time _____		<input type="checkbox"/> General Toxicology Panel Chlamydia / Gonorrhea / Trichomonas <input type="checkbox"/> Chlamydia & Gonorrhea Screen <input type="checkbox"/> Prenatal Screen <input type="checkbox"/> Vagina ¹ <input type="checkbox"/> Endocervical ² <input type="checkbox"/> Urine, First Catch ³ <input type="checkbox"/> Urethra ² <input type="checkbox"/> Rectal ¹ <input type="checkbox"/> Throat ¹ <input type="checkbox"/> Eye ¹ <input type="checkbox"/> Trichomonas Vaginalis Screen Female ≥ 14Y: <input type="checkbox"/> Vagina ¹ <input type="checkbox"/> Endocervical ² <input type="checkbox"/> Urine, First Catch ³		
				Additional Tests		



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		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

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
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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
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Prescription Authorization

Patient:
Address:
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	<u>1</u>
Repeats	<u>2</u>

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	<u>1</u>
Repeats	<u>1</u>

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	<u>1</u>
Repeats	<u>1</u>

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 _____

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