

Last Name

First Name

Salutation

Changed

Save

Cancel

Address 1

Address 2

City

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

+

PHN

Plans (0)

F2

SubPlan Code	Group ID	Client ID	Expiry

Comments (0)

F2

Ins

Del

Topic	Comment
Program:	
Student ID:	

Load

Delete



## Record of Immunization Form

Name: \_\_\_\_\_  
Last name First Name Middle Initial  
Date of birth (MM/DD/YY): \_\_\_\_\_  
Program Name: \_\_\_\_\_ Program Start Date: \_\_\_\_\_  
Student ID #: \_\_\_\_\_ Email: \_\_\_\_\_

### Tuberculin Skin Test (TST)

- Single baseline TST must be done within 1 year of program start date. TST must be read 48 to 72 hours later by a qualified provider, not self-read. If you have a Positive TB Skin Test result, you must also submit a chest x-ray result (done within 6 months of program start date.)

☐ Check this box if a TB Skin Test is not required for your program

Date given: \_\_\_\_\_ Given by: \_\_\_\_\_  
Date read: \_\_\_\_\_ Read by: \_\_\_\_\_  
Result: ☐ Negative ☐ Positive \_\_\_\_\_ mm induration

**TB Test results MUST BE recorded in both words and numbers (e.g. Negative, 0 mm induration)**

### CHEST X-RAY (only required for Positive TST)

Date of chest x-ray: \_\_\_\_\_ Result: \_\_\_\_\_

**ATTACH A COPY OF CHEST X-RAY RESULTS**

### Varicella

- Documented history of 2 doses of Varicella-containing vaccine **OR**
- Laboratory evidence of immunity **OR**
- Self-reported history or physician diagnosed varicella disease prior to January 2001 **OR**
- Physician diagnosed shingles disease (please provide a letter from your physician)

☐ Check this box if Varicella is not required for your program

Lab evidence of Immunity (titres) Date: \_\_\_\_\_ Result: ☐ Immune ☐ Not Immune  
Varicella vaccine Dose #1: \_\_\_\_\_ Dose #2: \_\_\_\_\_  
History of Chickenpox ☐ Yes ☐ No Year (if known): \_\_\_\_\_  
History of Shingles ☐ Yes ☐ No ☐ Please provide a letter from physician

### Measles, Mumps, Rubella

- Documented history of 2 doses of MMR vaccine. **Serology is not accepted.**

MMR vaccine Dose #1 Date: \_\_\_\_\_ Dose #2 Date: \_\_\_\_\_

### Td (Tetanus/Diphtheria) Primary Series

- Documentation of a completed Td Primary Series (minimum 3 doses). Reinforcing dose of Tetanus/Diphtheria/Pertussis vaccine within the last 10 years. (Only the dates of the last 3 doses are required for this form.)

Complete Td Primary Series ( $\geq 3$  doses) ☐ Yes ☐ No

Dose #1 Date: \_\_\_\_\_ Dose #2 Date: \_\_\_\_\_ Dose #3 Date: \_\_\_\_\_

### Adult Tdap booster (Tetanus/Diphtheria/Pertussis)

- If no documented history of a dose of acellular pertussis vaccine as an adult (**at or over the age of 18**): 1 dose of Tdap (Adacel or Boostrix vaccine), **regardless of the interval since the last dose of tetanus containing vaccine.**

Tdap Adult booster ☐ Adacel vaccine ☐ Boostrix vaccine Date: \_\_\_\_\_

### Hepatitis B Series

- Documentation of a completed Hepatitis B Series. (An alternative adolescent schedule of 2 doses of 1.0 mL administered on day 0 and 6 months later is also acceptable.)

☐ Check this box if Hepatitis B is not required for your program

Complete Hepatitis B Series

☐ Yes

☐ No

Dose #1 Date: \_\_\_\_\_

Dose #2 Date: \_\_\_\_\_

Dose #3 Date: \_\_\_\_\_

Hep B Booster dose(s) if necessary

Booster #1 Date: \_\_\_\_\_

Booster #2 Date: \_\_\_\_\_

Booster #3 Date: \_\_\_\_\_

### Hepatitis B Post-Immunization Serology

- Hepatitis B post-immunization serology should be completed 1 to 6 months after completion of the Hep B series or at the time of assessment.

Lab evidence of Hep B Immunity  
(Hep B Surface Antibody)

Date: \_\_\_\_\_

Result: ☐ Immune ☐ Not Immune

Titres (if known): \_\_\_\_\_ IU/L

### Polio Primary Series

- Documentation of a completed Polio Primary Series (minimum 3 doses).

☐ Check this box if Polio is not required for your program

Complete Polio Primary Series (≥ 3 doses)

☐ Yes

☐ No

Dose #1 Date: \_\_\_\_\_

Dose #2 Date: \_\_\_\_\_

Dose #3 Date: \_\_\_\_\_

### Adult Polio booster

- One reinforcing dose of Polio received at **18 years of age or older** and at least 10 years after the primary series.

☐ Check this box if Polio is not required for your program

Adult Polio booster

Booster Date: \_\_\_\_\_

### Healthcare Professional Verification

This verifies the above individual has completed the **first doses** of all the recommended immunizations for their program, including a **TB Skin Test**, if applicable.

This verifies the above individual has completed **all** the recommended immunizations for their program and has been sent for **Post Hepatitis B Immunization serology**, if applicable.

Health Practitioner Signature: \_\_\_\_\_

Health Practitioner Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Health Unit Stamp

Health Unit Stamp

### School Verification (NAIT use only)

Nurse Signature: \_\_\_\_\_

Nurse Signature: \_\_\_\_\_



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		<b>*F</b> Denotes a <b>fasting test</b> <b>*I</b> Special instructions, see website		Hours Fasting _____ <input type="checkbox"/> Third Party Bill? Client _____
<b>Hematology / Coagulation</b>		<b>Endocrinology</b>		<b>Clinical Information</b>		
<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		<b>Drug Levels / Monitoring</b> <input type="checkbox"/> Ethanol Level, Blood <b>Therapeutic Drug Monitoring:</b> 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 _____		
<b>General Chemistry</b>		<b>Immunology / Serology</b>		<b>Antibiotics:</b>		
<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 <b>*F *I</b> <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		
<b>Lipid Panel</b>		<b>Cardiology</b>		<b>Urine Drug Testing Panels</b>		
<input type="checkbox"/> Lipid Panel <input type="checkbox"/> Cholesterol <input type="checkbox"/> Triglycerides <input type="checkbox"/> Cardiovascular Disease Risk Assessment (includes Lipid Panel)		<input type="checkbox"/> Electrocardiogram ECG to be read by: <input type="checkbox"/> DynaLIFE Panel <input type="checkbox"/> Other _____		Reason for Request _____ <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 _____		
<b>Required History:</b>		<b>Transfusion Medicine</b>		<b>OR</b>		
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		<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"/> General Toxicology Panel		
<b>Glucose Tolerance Tests</b>		<b>Sterile Body Fluid</b>		<b>Chlamydia / Gonorrhea / Trichomonas</b>		
<input type="checkbox"/> Glucose, Gestational Diabetes Screen (GDS) <input type="checkbox"/> Glucose Tolerance, Gestational, 2h <b>*F *I</b> <input type="checkbox"/> Glucose Tolerance, 2h <b>*F *I</b>		<input type="checkbox"/> Fluid Type _____ Source _____ Test(s) _____		<input type="checkbox"/> Chlamydia & Gonorrhea Screen <input type="checkbox"/> Prenatal Screen <input type="checkbox"/> Vagina <sup>1</sup> <input type="checkbox"/> Endocervical <sup>2</sup> <input type="checkbox"/> Urine, First Catch <sup>3</sup> <input type="checkbox"/> Urethra <sup>2</sup> <input type="checkbox"/> Rectal <sup>1</sup> <input type="checkbox"/> Throat <sup>1</sup> <input type="checkbox"/> Eye <sup>1</sup> <input type="checkbox"/> Trichomonas Vaginalis Screen Female ≥ 14Y: <input type="checkbox"/> Vagina <sup>1</sup> <input type="checkbox"/> Endocervical <sup>2</sup> <input type="checkbox"/> Urine, First Catch <sup>3</sup>		
<b>Miscellaneous</b>		<b>Urine</b>		<b>Additional Tests</b>		
<input type="checkbox"/> FIT Colorectal Cancer Screening (Age 50-74) <b>*I</b> <input type="checkbox"/> H. pylori <b>*I</b> <input type="checkbox"/> Hemoglobinopathy Investigation		<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				
		<b>24h Urine *I</b>				
		Total Volume _____ Start Date _____ Start Time _____ End Date _____ End Time _____				



# 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
------------------------------	-------------------------	-------------

**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:  
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 \_\_\_\_\_

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