THOMPSON RIVERS UNIVERSITY | School of Nursing

Dear TRU Nursing Student:

Immunization protects clients, health care workers and students from potentially debilitating complications of communicable or infectious diseases. All health care workers, including students, should be protected against vaccine preventable diseases. **Non-immunized students will not be allowed in the practice setting if there is an outbreak, thus impeding their success in the program. Moreover, practice facilities may not accept unvaccinated students on a unit.**

As this immunization record may take up to 6 months to complete, it is highly recommended that you start the immunization process immediately.

All Immunizations *must be complete prior to starting your practicum.*

First, have a TB skin test, as other vaccines can delay when this test can be done:

a. This test is not provided free. Make an appointment with a Travel Medicine and Vaccination Centre (TMVC) or a private provider. For the TMVC, phone 1-888-288-8682 or email http://www.tmvc.com/
b. TB skin tests requires 2 visits, 48 hours apart. A chest X-ray may be required and can take 2-4 weeks for results.
c. Have the Travel Medicine and Vaccination Center's nurse complete the TB skin test section at the top of the TRU immunization form.

2. **Determine your immunization status:**

a. Try to locate all of your personal immunization records.
b. Once you have located your records, make an appointment with either a Public Health Unit, Immunization Clinic, Nurse Practitioner or your Family Physician to determine what immunizations you may still require and if a blood test is needed to determine immunity.
c. Have the health care provider complete the TRU immunization form, including the appropriate dates, and sign the certification section.

3. **Submit a copy of your signed certified Student Immunization Record Form directly to:**

a. Kamloops campus- BScN students only: nursingpractice@tru.ca
b. Open Learning students: tru_ol_nursing@tru.ca
c. Williams Lake campus students: rrichardson@tru.ca
d. All other Kamloops campus students: nursing@tru.ca

NOTE: If you are in the process of completing the required immunizations, indicate your next appointment date(s), and provide proof after each subsequent dose. Updating the nursing school is the student's responsibility.

4. **Keep a copy for your records**

In Person/Mail:
Thompson Rivers University
School of Nursing, Office S204
805 TRU Way
Kamloops, BC V2C 0C8

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TRU/TRU-OL School of Nursing Student Immunization Record

Note: Please bring your previous immunization records to your appointment and have a **Public Health Care Provider/Physician complete and certify THIS** form to ensure validity.

No other form/documentation will be accepted as proof of completed immunization requirements.

Please also sign and date the bottom of this form in the Student's Signature area yourself, before submitting.

Last Name	First Name	Maiden Name (If applicable)	Day of Birth (yyyy/mm/dd)
Personal Health Number	**TRU ID #**	**Program**	**Date of Entry**

TB Skin Test (to be completed 6 months prior to commencement of program)
And/or Chest X-Ray (If TB Skin Test is positive or, if there is a history of a previous positive reaction)

TB Test Date:	**TB Read Date:**
Result: ☐ Positive ☐ Negative	**Read by:** (Signature of Health Care Provider and Agency Stamp)
A chest X-ray is required if the TB skin test is positive (or if there is a history of a previous positive reaction)	
Chest X-ray Date:	**Result:** ☐ Positive ☐ Negative

Tetanus, Diphtheria, Pertussis (Tdap) Vaccine			
Primary Series – (3 or 4 doses) in early childhood ☐ Yes ☐ No	**Dose #**	**Date**	**Health Care Provider Signature**
If YES, Date of last Td Booster: (Required EVERY 10 years after primary series)	**Tdap #1 (0 month)**		
	Td #2 (1 month after 1st dose)		
If NO, you will required the completion of a 3 dose series:	**Td #3 (6-12 months after 2nd dose)**		

Poliomyelitis - Inactivated Polio (IPV) Vaccine			
Primary Series – (3 doses) in early childhood ☐ Yes ☐ No	**Dose #**	**Date**	**Health Care Provider Signature**
If YES, Date of Polio Booster (>18 yrs): (ONE TIME only booster AND 10 years after the primary series was completed)	**IPV #1 (0 month)**		
	IPV #2 (1 month after 1st dose)		
If NO, you will require the completion of a 3 dose series:	**IPV #3 (6-12 months after 2nd dose)**		

Measles/Mumps/Rubella (MMR) Vaccine			
Proof of 2 MMR doses are required for all Health Care Workers. **Provide Dates**	**Dose #**	**Date**	**Health Care Provider Signature**
	MMR #1		
	MMR #2		

Varicella (VAR) Vaccine (Chicken Pox or Herpes Zoster)			
History of Disease – ☐ Yes ☐ No **If YES, include date:**	**Dose #**	**Date**	**Health Care Provider Signature**
If NO, Varicella Blood Test Result: ☐ Immune ☐ Not Immune	**VAR #1**		
If NOT immune, you will required 2 doses series:	**VAR #2 (6 weeks after 1st dose)**		

Hepatitis B (HB) Vaccine			
A HB blood test is required for proof of immunity.			
HB Blood Test: ☐ Immune ☐ Not Immune	**Dose #**	**Date**	**Health Care Provider Signature**
	HB #1		
Series Required?: ☐ Yes ☐ No **Provide Dates**	**HB #2**		
	HB #3		

Public Health/ Nurse Practitioner/ Physician Certification: I Certify that the above information is accurate and up-to-date.

Health Care Provider's Name	Health Care Provider's signature/Stamp	Date	Student's signature	Date