



IMMUNIZATION REQUIREMENTS  
RESPIRATORY THERAPY PROGRAM

**Note:** Please complete this form and sign it before submitting. A Public Health Care Provider/Physician certification is also required to prove validity. Form is due by **AUGUST 30**. Please keep a copy for your reference.

Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
(Last) (First) (If applicable)

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Student ID#: \_\_\_\_\_ Personal Health Number \_\_\_\_\_

Date of entry to program: \_\_\_\_\_  
(Month) (Year)

**1. TB SKIN TEST**

All students should have a **TB Skin Test** unless you are a known positive reactor or unless you have documented proof of a previous negative test result within the past 6 months, prior to commencement of the program.

TB Skin Test Date: \_\_\_\_\_ TB Read Date: \_\_\_\_\_ Result: \_\_\_\_\_ (mm)

Read By: \_\_\_\_\_  
(Signature of Health Care Provider & 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. It is the student's responsibility to provide this information to the University.

Chest x-ray Date: \_\_\_\_\_ Result: \_\_\_\_\_

*Signature of Health Care Provider below indicated CXR has been read and is negative for TB.*

\_\_\_\_\_  
Signature of Health Care Provider

*Please list all dates for immunizations in the following order: Year/Month/Day (Adult >18 years)*

**2. TD – Tdap TETANUS DIPHTHERIA PERTUSSIS**

**Primary Series** - Tetanus/Diphtheria/Pertussis (3 or 4 doses) in early childhood: Yes \_\_\_\_ No \_\_\_\_

**If answered yes:** (received in childhood)

**Date** of Dose #3 or #4 (this is the last date of Primary Series) \_\_\_\_\_ (Date)

**Td Booster** \_\_\_\_\_ (Date) **A booster dose of tetanus** is required **every 10 years** after the primary series. This booster can be combined with other vaccines such as polio.

Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
(Last) (First) (If applicable)

## 2. TD – CONTINUED from Page 1

If answered no: (did not receive the primary series in early childhood) completion of **3 dose series** as an adult is required and include one dose of Tdap (to provide protection against pertussis):

Tdap (0 month) Dose #1: \_\_\_\_\_ (Date)

Td (1 month) Dose #2: \_\_\_\_\_ (Date)

Td (6 – 12 months after the 2nd dose) Dose #3: \_\_\_\_\_ (Date)

## 3. POLIO - IPV

Primary Polio Series- (3 doses) in early childhood: Yes \_\_\_\_\_ No \_\_\_\_\_

If answered yes: (received in childhood) A **ONE TIME** polio booster is required for healthcare workers.

Polio Booster: \_\_\_\_\_ (Date) Polio booster can be combined with other vaccines.

If answered no (did not receive the primary series in early childhood) completion of **3 dose series** as an adult is required.

Polio IPV Dose #1: \_\_\_\_\_ (Date) Polio IPV Dose #2: \_\_\_\_\_ (Date)

Polio IPV Dose #3: \_\_\_\_\_ (Date)

## 4. MMR- MEASLES, MUMPS, RUBELLA

2 doses of MMR are recommended for all Respiratory Therapy Students.

Measles, Mumps and Rubella (MMR) Vaccine #1: \_\_\_\_\_ (Date)

Measles, Mumps and Rubella (MMR) Vaccine #2: \_\_\_\_\_ (Date)

## 5. VARICELLA- CHICKEN POX

If Varicella disease history or date of vaccines cannot be confirmed, then a Varicella IgG titre must be completed to determine immunity.

History of Disease: Yes \_\_\_\_\_ No \_\_\_\_\_ OR Date (if known) \_\_\_\_\_

Varicella immunity (IgG antibody) Yes \_\_\_\_\_ No \_\_\_\_\_ If susceptible: Date \_\_\_\_\_

Varicella Vaccine Dose #1 \_\_\_\_\_ (Date) Dose #2 (6 wks after ) \_\_\_\_\_ (Date)

6. INFLUENZA - Annual vaccine as required Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First)

Maiden Name: \_\_\_\_\_  
(If applicable)

### 7. HEPATITIS B - HB

If necessary, the Hepatitis B series may be initiated upon entry into the RT program.

If you are 18 -19 years of age you need 3 doses (**0.5mLeach**) given at 0, 1 and 6 months.

If you are 20 years of age and older you need 3 doses (**1.0mLeach**) given at 0, 1 and 6 months.

**You must have your blood checked for HepB immunity even if you've been immunized.**

3-dose series:

Dose #1 (0 month): \_\_\_\_\_ (Date)

Dose #2 (1 month): \_\_\_\_\_ (Date)

Dose #3 (6 months): \_\_\_\_\_ (Date)

2-dose series (6th grade)

Dose #1 (0 month): \_\_\_\_\_ (Date)

Dose #2 (6 months): \_\_\_\_\_ (Date)

Hepatitis B Titres \_\_\_\_\_ (Date) HepB Immunity Yes \_\_\_\_\_ No \_\_\_\_\_

**Be sure your test is for immunity, NOT active disease.** They are different. Many people that have had the shots are no longer immune as the body metabolizes the injections.

### 8. COVID-19

Due to the variation in immunization dates within the **COVID-19** vaccine roll-out, some students may receive their vaccinations before others. If you have received your **COVID-19** vaccine already, please list the **dates** and **manufacturer** of vaccine administered.

Dose #1: \_\_\_\_\_ (Date)

Manufacturer: \_\_\_\_\_

Dose #2: \_\_\_\_\_ (Date)

Manufacturer: \_\_\_\_\_

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I certify that the information reported is accurate and up-to-date.

**Please keep a copy for your reference.**

\_\_\_\_\_  
(Signature of student)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature and stamp of **Public Health or Physician Certification** reviewing this document)

\_\_\_\_\_  
(Date)

Return to: **Tara Langley**, Program Assistant  
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