Vaccine(s) Administered for Southern Alberta Institute of Technology (SAIT) Health Program Practicum Requirements

Section 1: Student: please fill out in all information requested and have your Healthcare Professional fill out Section 2.
Return completed record, along with copies of ALL IMMUNIZATION RECORDS and TEST RESULTS to the SAIT Health Clinic using one of the following methods:

- **Fax** 1-403-284-8631 *Attn: Immunization Consult Appointment – date of appointment *
- **E-mail** health.services@sait.ca (subject line: Immunization Consult Appointment -date of appointment)

Last Name	First Name	Middle Name	◯ Male ◯ Female ◯ Other: ____________	SAIT ID# 000____________

Address:
Street City Province Postal Code Country

Cell Phone: ____________________
Home: ____________________
Other: ____________________

Date of Birth
_______/_________/_______
Year Month Day

Age:

Provincial Health Care Number: ______________________________
Issuing Province: ______________________________
International Student? ◯ **Yes** ◯ **No**

Resident/Visitor Status:

◯ **Alberta Resident (Canadian Citizen)** ◯ **New Permanent Alberta Resident** ◯ **Visitor to Alberta** ◯ **Not Yet an Alberta Resident:**

If not yet an Alberta Resident, what is your expected date of residency? ______________________________

Section 2: To Be Filled Out by Healthcare Professional Only

VACCINE	LOT#	DOSAGE	ROUTE	DATE GIVEN: yy/mm/dd	VACCINE SITE	GIVEN BY	INDICATIONS
Hepatitis B *Not required for Medical Office Assistant (MOA) or Health Information Management (HIM) students		◯ **0.5 mL** ◯ **1.0 mL**	**IM**		◯ **Left arm** ◯ **Right arm**		◯ **Must have 3 documented doses of Hep B** ◯ **Preliminary Serology Attached for:** **-HBsAg** **-anti-HBs** **-anti-HBc**
MMR (Measles, Mumps, Rubella)		◯ **0.5 mL**	**SC**		◯ **Left arm** ◯ **Right arm**		◯ **Serology NOT accepted; must have 2 documented doses.** ◯ **Routine Immunization** ◯ **Occupational**
dTap (Tetanus, Diphtheria, acellular Pertussis		◯ **0.5 mL**	**IM**		◯ **Left arm** ◯ **Right arm**		◯ **Routine Immunization** ◯ **Post Exposure** ◯ **Serology NOT accepted; Must have 2 documented doses, OR a documented primary childhood series** ◯ **1 dose of dTap after age 18 (DOB)**
Tuberculin PPD (Mantoux test) *Not required for Dental Assisting (DA) students in Alberta		◯ **0.1 mL**	**ID**	**Date Administered:** ________ **Date read:** ________ **Result:** ________ **mm**	◯ **Left arm** ◯ **Right arm**		◯ **Occupational**
Tuberculin PPD (Mantoux test) 2-Step *Required by Respiratory Therapy students only (1st Year)		◯ **0.1 mL**	**ID**	**Date Administered:** ________ **Date read:** ________ **Result:** ________ **mm**	◯ **Left arm** ◯ **Right arm**		◯ **Occupational**
Varicella		◯ **0.5 mL**	**SC**		◯ **Left arm** ◯ **Right arm**		◯ **Positive Varicella zoster IgG OR 2 documented Doses of Varicella vaccine** ◯ **Serology attached**

Informed consent has been obtained for the administration of vaccine(s) for the individual listed on this form.

Name (please print): ______________________________
Physician, Public Health Professional, or Pharmacist

Signature: ______________________________
(Sign) Date

Address:
____
Street Unit#
____
City Province Postal Code

Contact Phone Information
Business: ______________________________
Other: ______________________________

Or Stamp