



Immunization requirements

Welcome to the School of Health Sciences at Vancouver Community College (VCC). As a future health care professional you should be protected against vaccine preventable diseases. Up-to-date immunizations greatly reduce your risk of diseases.

As part of your Health Sciences program, you will be required to complete the Immunization Record before beginning your program. Proof of your immunization status is a requirement outlined in the provincial [Practice Education Guidelines](#).

These guidelines must be followed by all colleges and therefore their students when requesting clinical placements. The guidelines state that all individuals working in a health care facility should be protected against vaccine preventable diseases. This includes health care students on clinical placements. Clinical facilities may decline individual students for their placement if a student is unable to provide proof of immunizations or satisfactory serum titers and a TB screening.

Immunization updating - contact a [Public Health Unit](#) in your area or your Family Physician

TB skin testing - contact [BC Centre for Disease Control](#) (BCCDC) at 604.707.2692. Offices are located at 655 West 12th Avenue, Vancouver

Please note: completed TB tests should be submitted to VCC's [Registrar's Office](#) to be recorded on your student file.

Below is the list of the specific requirements for vaccine preventable diseases:

- **Diphtheria/Tetanus/Pertussis** - proof of basic immunization and booster in last 10 years with recommendation for 1 adult dose of Pertussis
- **Poliomyelitis** - proof of basic immunization series of polio vaccine
- **Measles, Mumps & Rubella (MMR)** - for those born after 1957, a proof of two doses of MMR vaccine or reactive serological test for immunity
- **Varicella Vaccination (Chicken Pox)** - proof of vaccination or a positive history
- **Influenza Vaccination** - proof of annual influenza vaccine
- **Hepatitis B** - proof of Hepatitis B vaccine series



Immunization Record

Broadway campus
1155 East Broadway, Vancouver, B.C. V5T 4V5

Downtown campus
250 West Pender St., Vancouver, B.C. V6B 1S9

p: 604.871.7000, option 3
f: 604.443.8450
e: registrar_office@vcc.ca
www **VCC.CA**

To complete this form:

1. Check with your family physician or local public health unit for childhood immunization records.
2. Take immunization records and this form to your doctor or public health nurse to review and complete.

When completed:

Please bring this form to your first day of class.

Personal information

| | | | |
|-------------------------|----------|-------------|------------|
| Last name (family name) | | First name | Student ID |
| Phone | Email | | |
| Address | | | |
| City | Province | Postal code | |

Immunization information

| | | |
|--|--|---|
| Tetanus/Diphtheria | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No record | DD/MM/YYYY - Last Tetanus vaccination |
| Pertussis | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No record | DD/MM/YYYY - Last Pertussis vaccination |
| Polio <input type="checkbox"/> Childhood primary series | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No record | DD/MM/YYYY - Last Polio vaccination |
| Measles, Mumps & Rubella (mandatory: 2 documented MMRs) | <input type="checkbox"/> MMR 1 <input type="checkbox"/> MMR 2 <input type="checkbox"/> No record (Reactive Serology required) | |
| Varicella (Chicken Pox) <input type="checkbox"/> I have had Chicken Pox (no titre is required) | <input type="checkbox"/> I have NOT had Chicken Pox: Varicella Titre date Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative DD/MM/YYYY | |
| DD/MM/YYYY - When? | Inadequate immunity requires 2 doses adult primary series: dose 1 dose 2 DD/MM/YYYY DD/MM/YYYY | |
| Hepatitis B Primary series (3 doses) complete | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No record | |
| Influenza Flu Vaccine (Record required for January intake only) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Certify information is correct and up-to-date

| | | |
|--|--------------------------------|-------------------|
| Student signature | Date - DD/MM/YYYY | |
| Name of health care provider reviewing this document | Health care provider signature | Date - DD/MM/YYYY |

The information on this form is collected under the authority of the BC Freedom of Information and Protection of Privacy Act (1996) and is needed to process any changes in your student record. If you have any questions about the collection and use of this information contact the Registrar's Office.