

TO BE COMPLETED BY PHYSICIAN				
Name of Student		Student Number		Date of Birth (Y/M/D)
<b>Mantoux Skin Test</b>	<b>Date given</b> Year/Month/Day	<b>Date Read</b> 48 - 72 h from testing	<b>Induration</b>	
Baseline 2 Step Mantoux Step 1				
Step 2 Within 7 days - 1 year of Step 1				
Step 1 Required Annually				
Step 1 Required Annually				
<b>If TB positive</b>		<b>Date &amp; Result (include chest x-ray report)</b>		
Chest X-Ray Every 2 years				
Chest X-Ray Every 2 years				
<b>Doctor's Note Annually If TB positive</b>			<b>Signature &amp; Date</b>	
Student is free from signs and symptoms of active tuberculosis				
Student is free from signs and symptoms of active tuberculosis				
<b>Immunization</b>	<b>Dose 1</b> Date given	<b>Dose 2</b> Date given	<b>Booster dose</b> Date given	<b>Immune</b> Yes/No/Indeterminate
MMR Measles, Mumps, Rubella				
Varicella Chicken Pox				
<b>Immunization</b>	<b>Date Primary Series Completed</b>		<b>Date of Last Booster</b>	
Polio				
<b>Immunization</b>	<b>1st vaccination date</b>	<b>2nd vaccination date</b> within 1 month of 1st	<b>3rd vaccination date</b> 5 months after 2nd dose	
Hepatitis B 1st series				
Hepatitis B 2nd series <b>Repeat if not immune</b>				

Immunity	Yes	No	Indeterminate
Hepatitis B			
Repeat Titres 1 month after last vaccination			
Immunization	Date of last Immunization	Booster Due every 10 years	
TDP Tetanus/Diphtheria/Pertusis			
Immunization	Date Received		
Influenza Vaccination			
Influenza Vaccination			
Physicians Stamp			
Physician Name	Telephone No.	Date of Completion	Signature