THOMPSON RIVERS UNIVERSITY

Medical Laboratory Assistant Certificate
Medical Requirements

Submit the completed and signed form to: olhealthscience@tru.ca or mail to:
Program Administrator, Science
805 TRU Way, Kamloops, BC V2C 0C8

First Name: _____ Last Name: _____ Middle Initial: ___

Date of birth: _____ (DD/MM/YY) Student ID #: _____

Requirement for program admission

Hepatitis B - HB

18-19 years of age, 3 doses (0.5 mL each) given at 0, 1 and 6 months.
20 years of age and older born in 1980 or later, 3 doses (1.0 mL each) 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): _____ (DD/MM/YY)
Dose #2 (1 month): _____ (DD/MM/YY)
Dose #3 (6 months): _____ (DD/MM/YY)

2-dose series (6th grade):
Dose #1 (0 month): _____ (DD/MM/YY)
Dose #2 (6 month): _____ (DD/MM/YY)

Hepatitis B Titres _____ (DD/MM/YY) HEP B Immunity Yes ___ No ___

Titers are blood tests that check your immune status for vaccinations or diseases you may have received in the past.

Requirement for program placement

TB SKIN TEST

All students should have a TB Skin Test unless they are a known positive reactor or unless they have documented proof of a previous negative test result within the past 6 months, prior to commencement of the program. Those with a known positive reaction in the past should have a chest x-ray unless there is proof of previous chest x-ray results within 6 months.

TB Skin Test Date: _____ (DD/MM/YY) TB Read Date: _____ (DD/MM/YY)

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. A letter from the Health Unit will be provided to the student outlining TB Control recommendations when available. It is the student's responsibility to provide the information to the University.

Chest X-Ray Date: _____ (DD/MM/YY) Result: _____

_____

(Signature of Health Care Provider & agency stamp)

Signature of Health Care Provider indicates CXR has been read and is negative for TB.

Immunization Record

All dates for immunizations: Year/Month/Day (Adult >18 years)

TD – Tdap TETANUS DIPHTHERIA PERTUSSIS

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

If yes:

Date of Dose #3 or #4 (Last of Primary Series): _____ (YY/MM/DD)

TD Booster _____ (YY/MM/DD)
Booster dose of tetanus, is required every 10 years after primary series. This booster can be combined with other vaccines such as Polio.

If no:

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: _____ (YY/MM/DD)
Tdap (1 month) Dose #2: _____ (YY/MM/DD)
Tdap (6 -12 months after 2nd dose) Dose #3: _____ (YY/MM/DD)

POLIO - IPV

Primary Polio Series (3 doses) in early childhood: Yes ___ No ___

If yes, a ONE TIME Polio booster is required 10 years after primary series:

Polio Booster _____ (YY/MM/DD)
Polio Booster can be combined with other vaccines.

If no, completion of 3 dose series as an adult is required:

Polio IPV Dose #1: _____ (YY/MM/DD)
Polio IPV Dose #2: _____ (YY/MM/DD)
Polio IPV Dose #3: _____ (YY/MM/DD)

Measles, Mumps, Rubella (MMR)

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

Measles, Mumps and Rubella (MMR) Vaccine #1: _____ (YY/MM/DD)
Measles, Mumps and Rubella (MMR) Vaccine #2: _____ (YY/MM/DD)

Chicken Pox (Varicella Var)

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 ___ Date (if known): _____ (DD/MM/YY)

OR Varicella immunity (IgG antibody) Yes ___ No ___ Date: _____ (DD/MM/YY)

If susceptible:

Varicella Vaccine Dose #1: _____ (DD/MM/YY)

Dose #2 (6 weeks apart): _____ (DD/MM/YY)

Influenza

Annual (October to February) Influenza vaccine as required.

COVID

COVID Vaccine #1: _____ (YY/MM/DD)
COVID Vaccine #2: _____ (YY/MM/DD)

I certify that the information reported is accurate and up-to-date.
Keep a copy for your reference.

_____	_____	_____
Applicant Signature	Print Name	Date (DD/MM/YY)

Public Health or Physician Certification reviewing the document:

_____	_____	_____
Signature	Name/Stamp	Date (DD/MM/YY)