

Please provide written evidence of the following immunization requirements. These requirements are necessary for your clinical and hospital practical experience. You may find evidence of these requirements from either: Public Health Office, your Doctor's office, Parent or Guardian.

Complete this column

<p><b>Measles, Mumps &amp; Rubella (MMR)</b> If you do not have a record of having an MMR (measles, mumps and rubella), please obtain a booster shot from your local Public Health Office.</p>	<p><u>Measles</u> D _____ M _____ Y _____ <u>Mumps</u> D _____ M _____ Y _____ <u>Rubella</u> D _____ M _____ Y _____</p>
<p><b>Tetanus – Diphtheria</b> Primary series is usually done in childhood. We require that you have a booster within the past ten (10) years.</p>	<p><u>Tetanus – Diphtheria</u> D _____ M _____ Y _____</p>
<p><b>Polio</b> Primary series is usually done in childhood.</p>	<p><u>Polio Childhood Series</u> D _____ M _____ Y _____</p>
<p><b>Varicella (Chicken Pox)</b> Provide verbal confirmation of having had the disease. If you have not had Chicken Pox, or if you are unsure, a Varicella titre should be performed to determine whether you are negative or positive. This blood work can be drawn at your doctor's office. We will need a copy of the result.</p>	<p><u>Chicken Pox Disease</u> Yes _____ No _____ <u>Date of Varicella Titre</u> D _____ M _____ Y _____ <u>Results of Varicella Titre</u> Pos: _____ Neg: _____</p>
<p><b>Mantoux (tuberculosis testing)</b> This will apply to all students who have never been tested or to students who tested negative over one year ago. If you tested POSITIVE in the past, you do not need the test, but we require a copy of your last chest X-ray, having been done within the past two years.</p>	<p><u>Mantoux Test</u> D _____ M _____ Y _____ Result Pos: _____ Neg: _____ Date of chest X-ray D _____ M _____ Y _____ Results ( _____ )</p>
<p><b>Flu Shot</b> A current Year's Flu Shot must be recorded.</p>	<p><u>Flu Shot for 20 _____ Year</u> D _____ M _____ Y _____</p>
<p><b>Hepatitis A / Hepatitis B (TwinRx)</b> This is a series of 3 injections over a 6-month period. If you have not been immunized, you may have these done at your local doctor's office or Public Health Office. The first 2 injections must be complete prior to registration.</p>	<p><u>1</u> D _____ M _____ Y _____ <u>2</u> D _____ M _____ Y _____ <u>3</u> D _____ M _____ Y _____</p>

**PLEASE SEND IMMUNIZATION RECORDS AND LAB REPORT TO:**

ERRS Inc. Inquiries: (204) 946-5100  
401 – 250 McDermott Ave. Fax: (204) 946-5200  
Winnipeg, MB R3B 0S5

**IMPORTANT NOTE: Keep a copy of this form for your personal records**

**Student Information**

Location: \_\_\_\_\_ Commencement Date: \_\_\_\_\_  
Name:(last, first and second) : \_\_\_\_\_,  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ - \_\_\_\_\_  
Phone: (HM) \_\_\_\_\_ (BUS) \_\_\_\_\_  
Date of Birth: D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_ Female: \_\_\_\_\_ Male: \_\_\_\_\_  
Manitoba Health Number (6 digit) \_\_\_\_\_ - \_\_\_\_\_ (9 digit) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

The Privacy Laws of Canada and Manitoba bind ERRS INC. in the protection of your personal health information. Please review our Privacy Policy in our Student Manual.

If you or your health care provider have any concerns, please contact our office @ (204) 946-5100

\*\* \_\_\_\_\_ Date: \_\_\_\_\_  
**Signature of Physician, Health Care Provider, or written documentation.**