



# THOMPSON RIVERS UNIVERSITY

## Medical Laboratory Assistant Certificate Medical Requirements

Submit the completed and signed form to: [olhealthscience@tru.ca](mailto: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)

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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)