UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

FACULTY OF DENTISTRY IMMUNIZATION/CPR RECORD

Last Name	First Name	Middle Initial

Student Number #	Birth Date (DD/MM/YY)	Phone

Mailing Address	Email

Degree Program or Position (Check One)

☐ Doctor of Dental Surgery (DDS) ☐ IDAPP

☐ Graduate Program Dentistry ☐ Other

This section to be completed and signed by your physician:

Required Immunization	Dates Immunization Received (DD/MM/YY)			Antibody Titre Results* or Laboratory Diagnosed History of Disease	
				Date	Results
Tetanus, diphtheria, pertussis (Td/Tdap) 1 dose within past 10 years	Dose 1				
Polio (IPV) Primary Course	Dose 1				
German Measles (Rubella) 2 doses after age 12 months	Dose 1	Dose 2			
Measles (Rubeola) 2 doses after age 12 months	Dose 1	Dose 2			
Mumps 2 doses after age 12 months	Dose 1	Dose 2			
Varicella (Chicken Pox) 2 doses	Dose 1	Dose 2			
Hepatitis B or A/B Series of 3 doses*	Dose 1	Dose 2	Dose 3		
Post-vaccination Serology Test (all applicants)* **1. Hepatitis B Surface Antibodies (anti-HBs)**					
Additional Post-vaccination Serology Tests (for applicants from countries endemic with HB – High & Intermediate)*					
1. Hepatitis B Surface Antigen (HBsAg)					
2. Hepatitis B Core Antibodies (anti-HBc)					
Baseline PPD (Tuberculosis Screening) 2-Step Mantoux	Step 1			Induration	
	Step 2			Induration	
Annual 1-Step Mantoux	Step 1			Induration	

If there is a documented prior positive TST, previous treatment for active TB, or previous treatment for latent TB, a TST is not required. Medical evaluation and a chest X-ray within 1 year are required.

Date of Chest X-ray: ___ / ___ / ___. Please attach copies of chest X-ray report.
DD MM YY

** Copies of antibody titre results must accompany this form.*

Physician Signature: _____ Date: _____

Influenza (Annual vaccine is recommended but not mandatory).			
Year 1	Year 2	Year 3	Year 4
COVID-19 (vaccination is recommended but not mandatory)			
Dose 1 - Date	Dose 2 - Date		
CPR / AED Certification (Annual renewal is recommended).			
Year 1		Year 2	

Authorization for Disclosure of Information

I understand that it is my responsibility to inform the appropriate personnel of any communicable disease, special need or medical condition, which may place me at a risk or pose a risk to others during clinical placements. The information on the immunization form will be kept confidential within my clinical site. However, under the following circumstances and for the duration of the program, I authorize the release of this immunization record to: 1. The clinical site personnel where an occupational exposure occurs; 2. The treating medical site/institution (if required); 3. Another clinical placement site (if requested).

_____ _____

Signature of Student Date

Return Completed form to: Clinic Office, Room 206 Faculty of Dentistry
University of Toronto. 124 Edward Street, Toronto, Ontario M5G 1G6. Forms may also be faxed to 416 979 4767.
For questions regarding this form, please call Ms. Anna Pullano 416 864 8299