Parry Sound Campus Only  
Communicable Disease Screening 2019/2020

Welcome new students!
Please have the attached form completed and sent in before August 1st 2019 to avoid any placement delays. Include copies of blood test results and immunization records. The Campus Health Centre will review your records annually and provide you with proof of clearance for academic placement. There is a $35.00 administrative fee which can be paid over the phone with a credit card or by mailing a cheque addressed to the Campus Health Centre as below. Cards will then be sent to the Parry Sound Campus for pick up. If you have any questions about this form call: 705-474-7600 ext. 5261.

Immunization records are available online with Immunization Connect Ontario, an application accessible from most Ontario Public Health Unit websites or directly from your local Public Health Unit. All documentation should be signed by a licensed health care professional.

Program Requirements for tuberculosis testing
Most students who will attend an academic placement outside the college or university must provide proof of one documented two step TB test (TST) performed at any time prior to clinical placement. This can be completed at your family doctor’s office or your local Health Unit.

Tuberculosis screening is required annually.
Students can complete annual screening for TB exposure by calling the Campus Health Centre or providing proof of a negative one step TST each year (must have prior two step). TST fees are covered by the Ontario Health Insurance Plan (OHIP) when required for school program placement.

Before sending forms please confirm:
- Student information section is fully completed on page 1
- Consent is signed on page 2
- Immunization screening section is filled and signed by a health care provider
- Immunization records and blood test results are attached

Fax to:
1-705-495-7909

Or mail:
Attention: Campus Health Centre
Canadore College/Nipissing University
100 College Drive
North Bay ON
P1B 8K9

These forms cannot be emailed
Communicable Disease Screening 2019/2020

1. Please have your health care provider complete this form
2. Attach copies of immunization records and blood test results
3. **Fax to 705-495-7909** or mail to Campus Health Centre by August 1, 2019

| Name: ______________________ | DOB (DD/MM/YY): __________________ | Phone: ____________ |
| Health Card: __________________ | Program (i.e. ECE, SSW, RPN, PSW, etc.): __________________ |
| Permanent Address: ________________ | |
| Student #: ______________________ | Gender indicated on health card: | Male ☐ | Female ☐ |

### Tuberculosis Skin Testing (TST)

New students involved in a community academic placement require documentation of a two-step TB test.

If a valid two step has been done greater than one year ago and documented on this form a recent one step TST is sufficient.

*Do not give live vaccine (MMR or Varicella) with step 1 of 2 step TB test

<table>
<thead>
<tr>
<th>Two Step TB Test:</th>
<th>Recent One Step:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1.</strong> Date given: ________</td>
<td>Date given: ________</td>
</tr>
<tr>
<td>Induration (mm): ________</td>
<td>Induration (mm): ________</td>
</tr>
<tr>
<td>Date read: ________</td>
<td>Date read: ________</td>
</tr>
<tr>
<td>Interpretation: ________</td>
<td>Interpretation: ________</td>
</tr>
<tr>
<td><strong>Step 2.</strong> Date given: ________</td>
<td></td>
</tr>
<tr>
<td>Induration (mm): ________</td>
<td></td>
</tr>
<tr>
<td>Date read: ________</td>
<td></td>
</tr>
<tr>
<td>Interpretation: ________</td>
<td></td>
</tr>
</tbody>
</table>

### Positive Tuberculosis Testing

If TB testing is positive or if you have had a previous positive TB test,

please make sure the last page is filled in by a physician and included with these forms.

### Measles Mumps and Rubella

Proof of two MMR (Measles, Mumps & Rubella) vaccines (not one MMR and one Measles) or blood test indicating immunity. Record the date of vaccine or attach laboratory results showing immune status if vaccine history is unavailable. Blood work results are not necessary if vaccine record includes two MMR vaccines.

| MMR #1: __________________ | (date) |
| MMR #2: __________________ | (date) |
| **OR** | |
| Titre Results: __________________ | |
| Date of Titre: __________________ | |
Tetanus, Diphtheria, and Pertussis Vaccine

*Booster required if last Tdap was before age 18*

According to the Ontario Hospital Association: “All adult (18 and older) health care workers, regardless of age, should receive a single dose of tetanus diphtheria acellular pertussis (Tdap/Adacel/Boostrix) for pertussis protection if not previously received in adulthood. The adult dose is in addition to the routine adolescent booster dose... The interval between the last tetanus-diphtheria booster and the Tdap vaccine does not matter”.

<table>
<thead>
<tr>
<th>Last Tdap/Adacel/Boostrix:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(date)</td>
</tr>
<tr>
<td>(age)</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Tdap</td>
<td>□ Adacel</td>
<td>□ Boostrix</td>
</tr>
</tbody>
</table>

(please check one)

Varicella (Chicken Pox)

You will need ONE of the following:
- Proof of two doses of the Varicella vaccine OR
- Blood work results indicating immunity (please include copy of lab results)

<table>
<thead>
<tr>
<th>Varivax #1:</th>
<th>(date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varivax #2:</td>
<td>(date)</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td>Titre Results:</td>
<td></td>
</tr>
</tbody>
</table>

Date of Titre: __________________________

Hepatitis B

Hepatitis B Immunity is required for the following programs: BScN, Practical Nursing, Personal Support Worker, Community and Justice Services, Dental Hygiene, Mental Health and Addiction Worker and Respiratory Therapy, Physiotherapist Assistant and Occupational Therapist Assistant.

You will need proof of the two dose or three dose series of Hepatitis B vaccine. Blood work confirming immunity is also required at least one month after the last dose of Hepatitis B vaccine. Two Hepatitis vaccines (Engerix B, Twinrix, or Recombivax) are required before a student can be cleared for placement.

*NOTE: Any student who has a hospital placement should have Hepatitis vaccination and proof of immunity.

<table>
<thead>
<tr>
<th>Hepatitis B #1:</th>
<th>(date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B #2:</td>
<td>(date)</td>
</tr>
<tr>
<td>Hepatitis B #3:</td>
<td>(date If three dose series)</td>
</tr>
<tr>
<td>Titre Results:</td>
<td></td>
</tr>
<tr>
<td>Date of Titre:</td>
<td></td>
</tr>
</tbody>
</table>

Booster if required: _______________________

(please include copy of lab results)

Consent:

I, _______________________________ (name of student),
consent to release my immunization status to my program placement coordinator if required.

Signature: ____________________________
Date: ________________________________

TO BE FILLED OUT BY A HEALTH CARE PROVIDER:

Completed by: ________________________________
Signature: ________________________________
Date: ________________________________
Address and telephone or office stamp: ________________________________________________
Positive TB Test Report
Communicable Disease Screening

Name: ______________________ DOB (DD/MM/YY): ___________ Phone: ______________
Health Card: ___________________ Program (i.e. ECE, SSW, RPN, PSW etc.): ________________
Permanent Address: _____________________________________________________________
Student #: ______________________ Gender indicated on health card: Male ☐ Female ☐

I, ______________________ (print name) consent to release the medical information requested on this
form to the Campus Health Centre.

Signature: ______________________ Date: ____________________________

Please have your physician fill in the section below

If student has had a positive TB test, proof of investigations for latent and active TB must be provided (i.e. chest
X-ray, review of symptoms and if warranted, sputum samples for acid fast bacilli and mycobacterial culture).

Positive TB Test Details:                                                                                   Review of symptoms (circle one):

Date given: __________________________________________
Date read: __________________________________________
Results: _____________________________________________
BCG vaccine: _______________________________________
Chest X-ray date: _________________________________
Chest X-ray results: _______________________________
Sputum results if warranted: _________________________

*Please attach all x-ray and laboratory results and note
any other relevant information

I have examined the above named student and find them clear of any signs or symptoms of tuberculosis.

Name: ______________________ Office Stamp: ______________________
Date: ______________________
Signature: ____________________