

# IMMUNIZATION REQUIREMENTS

Students entering the \_\_\_\_\_ at St. Lawrence College are required to complete this Immunization - Communicable Disease Form. Failure to complete may result in the student being ineligible for clinical/practical/laboratory participation.

Mandatory Medical Requirements: to be completed by your health care provider (Physician, Nurse Practitioner).

Steps to follow:

1. Download this immunization form.
2. Obtain a copy of your immunization records from the Public Health Unit responsible for maintaining immunization records for your high school.
  - Contact information for all Ontario Public Health Departments can be found on their web site: <https://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx>
  - For students from Kingston High Schools, visit: <https://kfla.icon.ehealthontario.ca/#!/welcome>
  - For students from Brockville High Schools, visit: <https://lgl.icon.ehealthontario.ca/#!/welcome>
  - For students from Cornwall High Schools, visit: <https://eohu.icon.ehealthontario.ca/#!/welcome>
  - If you are unable to obtain records, please consult with a St. Lawrence College Campus Health Centre Nurse: 613-544-5400 Ext. 5502.
3. **PLEASE SET YOUR APPOINTMENTS AS SOON AS POSSIBLE TO AVOID DELAYS.** It takes time to complete all immunization requirements. If you require hepatitis B vaccination the first 2 doses are given 1 month apart. If an adult series for tetanus, diphtheria, polio and pertussis is required, the first 2 doses are 1 month apart. Therefore, do not wait to start this process.
  - **Please note that you may be delayed or denied placement and or be required to pay late fees depending on your program, if immunization requirements are not completed on time.**
4. Please keep all of your records. Your Student Placement Facilitator will be emailing your SLC email account in future with instructions on how to provide your documentation to the College for verification. **Continue to monitor your SLC email for updates regarding immunization submission instructions.**

Questions? For placement or submission related inquiries, please email your appropriate Student Placement Facilitator. For health or immunization related questions please email [immunizations@sl.on.ca](mailto:immunizations@sl.on.ca).



Name:

Student ID #:

Program:

## Measles Mumps Rubella (MMR) Vaccine

Please complete: Option 1 or 2.

Option	Requirement	Authorization
	Documentation of two MMR vaccines are required.  If no records available, bloodwork to determine immunity to MMR is required.  Please refer to the <b>Canadian Immunization Guidelines</b> as needed.	
<b>OPTION #1</b>	<b>Immunization</b>	
	Date of 1 <sup>st</sup> MMR dose: _____  Date of 2 <sup>nd</sup> MMR dose: _____	_____ Signature and designation of attesting MD or RN  _____ Date
<b>OPTION #2</b>	<b>Serology</b>	
	Date of test: _____  Result ( <b>attach report</b> ):  Measles: <input type="checkbox"/> Negative <input type="checkbox"/> Positive  Mumps: <input type="checkbox"/> Negative <input type="checkbox"/> Positive  Rubella: <input type="checkbox"/> Negative <input type="checkbox"/> Positive  <u>If serology negative/indeterminate:</u>  Date of MMR booster: _____	<div>OFFICE STAMP</div>



Name:

Student ID #:

Program:

## Varicella (Chicken Pox) Vaccine

Please complete: Option 1 or 2.

Option	Requirement	Authorization
	Documentation of two varicella vaccines are required. Those who received only one dose of varicella vaccine should be given a second dose.  If no records available, bloodwork to determine immunity to varicella is required.  Please refer to the <b>Canadian Immunization Guidelines</b> as needed.	
<b>OPTION #1</b>	<b>Immunization</b>	
	Date of 1 <sup>st</sup> varicella dose: _____  Date of 2 <sup>nd</sup> varicella dose: _____	_____ Signature and designation of attesting MD or RN  _____ Date
<b>OPTION #2</b>	<b>Serology</b>	
	Date of test: _____  Result ( <b>attach report</b> ): <input type="checkbox"/> Negative <input type="checkbox"/> Positive  <u>If serology negative/indeterminate:</u>  Date of 1 <sup>st</sup> varicella dose: _____  Date of 2 <sup>nd</sup> varicella dose (if required): _____	<div>OFFICE STAMP</div>



Name:

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Program:

## Hepatitis B (HB) Vaccine

Complete Immunization and Serology.

Requirement	Authorization																
<p>Documented proof of Hepatitis B immunity through immunization records and antibody testing is required.</p> <p>If serology shows insufficient immunity, please repeat series as appropriate then re-titre.</p> <p>Please refer to the <b>Canadian Immunization Guidelines</b> as needed.</p> <p><b>1. <u>Immunization-Hepatitis B (2 or 3 dose series)</u></b></p> <table border="1"><thead><tr><th></th><th>1<sup>st</sup> Dose</th><th>2<sup>nd</sup> Dose</th><th>3<sup>rd</sup> Dose</th></tr></thead><tbody><tr><td>Dates:</td><td></td><td></td><td></td></tr></tbody></table> <p><b>AND</b></p> <p><b>2. <u>Hepatitis B antibody titre (HBsAb)</u></b></p> <p>Date of titre: _____</p> <p>Result (<b>attach report</b>): <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p> <p><b>If required, repeat HB vaccine series:</b></p> <table border="1"><thead><tr><th></th><th>1<sup>st</sup> Dose</th><th>2<sup>nd</sup> Dose</th><th>3<sup>rd</sup> Dose</th></tr></thead><tbody><tr><td>Dates:</td><td></td><td></td><td></td></tr></tbody></table> <p><b>THEN</b></p> <p><b>3. <u>Repeat HBsAb</u></b></p> <p>Date of test: _____</p> <p>Result (<b>attach report</b>): <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p>		1 <sup>st</sup> Dose	2 <sup>nd</sup> Dose	3 <sup>rd</sup> Dose	Dates:					1 <sup>st</sup> Dose	2 <sup>nd</sup> Dose	3 <sup>rd</sup> Dose	Dates:				<p>_____ Signature and designation of attesting MD or RN</p> <p>_____ Date</p> <p>_____ <i>OFFICE STAMP</i></p>
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	1 <sup>st</sup> Dose	2 <sup>nd</sup> Dose	3 <sup>rd</sup> Dose														
Dates:																	



Name:

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## Tetanus/Diphtheria/Pertussis Vaccine

Please complete: Option 1 or 2.

Option	Requirement	Authorization								
	Documented proof of a primary series is required, or an adult catch-up series will be needed. A booster dose of Pertussis is required for all adults.  Please refer to the <b>Canadian Immunization Guidelines</b> as needed.									
<b>OPTION #1</b>	<b>Immunization</b>									
	<b>Attach documented proof</b> of a primary series  Date of recent booster: _____  Vaccine type: _____	_____ Signature and designation of attesting MD or RN  _____ Date								
<b>OPTION #2</b>	<b>Adult Catch-up Series</b>									
	<table><tbody><tr><td>Dose:</td><td>1<sup>st</sup> (Tdap)</td><td>2<sup>nd</sup> (TD)</td><td>3<sup>rd</sup> (TD)</td></tr><tr><td>Dates:</td><td></td><td></td><td></td></tr></tbody></table>	Dose:	1 <sup>st</sup> (Tdap)	2 <sup>nd</sup> (TD)	3 <sup>rd</sup> (TD)	Dates:				<div>OFFICE STAMP</div>
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Dates:										

## Student Consent for Release of Information/Declaration

I understand and agree that my immunization record will be recorded in the Campus Health Centre Electronic Medical Records system and only accessible to Campus Health Centre Personnel. Only my clearance to participate in clinical/laboratory will be communicated with my Student Placement Facilitator.

Student Signature:

Date (MM/DD/YYYY):