

Program Immunization- Communicable Disease Form

Students entering the at St. Lawrence College are required to complete the following Immunization - Communicable Disease Form. Incomplete requirements may impact eligibility for clinical/practical/laboratory participation.

Steps to follow:

1. Download this Immunization-Communicable Disease Form.
2. Collect copies of available immunization records.
 - Immunization records may be located from the Ontario Public Health Unit responsible for maintaining your immunization records.
 - Eastern Ontario Health Unit: <https://eohu.icon.ehealthontario.ca/#!/welcome>
 - Kingston, Frontenac, Lennox & Addington Public Health: <https://kfla.icon.ehealthontario.ca/#!/welcome>
 - Leeds, Grenville and Lanark District Health Unit: <https://lgl.icon.ehealthontario.ca/#!/welcome>
 - Contact information for all Ontario Public Health Departments can be found here: <https://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx>
 - Additionally, you may be able to locate immunization records from your primary care provider or personal records (e.g., immunization cards/booklets).
3. Schedule an appointment with an SLC Campus Health Centre nurse or your primary care provider to review your immunization records and complete your form.

Campus Health Centre appointment link: <https://bit.ly/Book-an-appointment-at-CampusHealthCentre>

Brockville

Phone: 613-345-0660 ext. 5524

Email: HealthCentreB@sl.on.ca

Room 250B

Cornwall

Phone: 613-933-6080 ext. 5525

Email: HealthCentreC@sl.on.ca

Room A111

Kingston

Phone: 613-544-5400 ext. 5521

Email: HealthCentreK@sl.on.ca

Room 01220

4. Submit your Immunization-Communicable Disease Form and accompanying documentation to immunizations@sl.on.ca. An SLC Campus Health Centre nurse will review your submission and contact you to confirm immunization completion or arrange an appointment to ensure timely completion and next steps.

Please note:

- It is important to complete your Immunization-Communicable Disease Form as soon as possible to avoid delays. The immunization process can be lengthy.
- Depending on your program, there may be a deadline to complete your Immunization-Communicable Disease Form. Please contact your program to confirm.

Questions?

For questions regarding the Immunization - Communicable Disease Form, please contact immunizations@sl.on.ca or an SLC Campus Health Centre location (see contacts above).



Name:

Student ID #:

Program:

Tuberculosis Skin Testing (TB skin test, TST, Mantoux test)

Please complete: Option 1, 2 or 3.

Option	Requirement	Authorization																		
OPTION #1	TB Skin test (2-step)																			
For students who: <ul style="list-style-type: none">Have never received a 2-step TB skin test OR <ul style="list-style-type: none">Are unable to provide documentation of receiving a 2-step TB skin test	<p>An initial 2-step TB skin test is required for anyone completing TB skin testing. If there is a negative result, subsequent TB skin testing will be a 1-step (with supporting documentation).</p> <p>Please refer to TB skin testing guidelines from the Public Health Agency of Canada.</p> <table border="1"><thead><tr><th>1st</th><th>TB skin test plant</th><th>TB skin test read</th></tr></thead><tbody><tr><td>Dates:</td><td></td><td></td></tr><tr><td colspan="3">Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration</td></tr></tbody></table> <p>THEN</p> <table border="1"><thead><tr><th>2nd</th><th>TB skin test plant</th><th>TB skin test read</th></tr></thead><tbody><tr><td>Dates:</td><td></td><td></td></tr><tr><td colspan="3">Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration</td></tr></tbody></table> <p><u>If TB skin test result is positive:</u></p> <p>Required documents:</p> <ul style="list-style-type: none">Attach copy of chest x-ray report, completed within the last 12 monthsAttach any subsequent referral/treatment with your completed Immunization - Communicable Disease Form	1st	TB skin test plant	TB skin test read	Dates:			Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration			2nd	TB skin test plant	TB skin test read	Dates:			Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration			<hr/> <p>Signature and designation of attesting MD, RN or RPN</p> <hr/> <p>Date</p> <div style="border: 1px dashed black; height: 150px; margin-top: 20px; text-align: center; padding-top: 50px;"><i>OFFICE STAMP</i></div>
1st	TB skin test plant	TB skin test read																		
Dates:																				
Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration																				
2nd	TB skin test plant	TB skin test read																		
Dates:																				
Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration																				



Name:

Student ID #:

Program:

Tuberculosis Skin Testing Continued

Option	Requirement	Authorization																											
OPTION #2	TB Skin test (1-step)																												
<p>For students who:</p> <ul style="list-style-type: none"> Have documentation of a previous 2-step TB test with a negative result <p>AND</p> <ul style="list-style-type: none"> Require an up to date 1-step TB skin test 	<p>A 1-step TB skin test is required for students who have completed a prior 2-step TB skin test.</p> <p>Please refer to TB skin testing guidelines from the Public Health Agency of Canada.</p> <p>1. <u>Provide results of previous 2-step TB skin test</u></p> <table border="1"> <tr> <td>1st</td><td>TB skin test plant</td><td>TB skin test read</td></tr> <tr> <td>Dates:</td><td></td><td></td></tr> <tr> <td>Result:</td><td colspan="2"><input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration</td></tr> </table> <table border="1"> <tr> <td>2nd</td><td>TB skin test plant</td><td>TB skin test read</td></tr> <tr> <td>Dates:</td><td></td><td></td></tr> <tr> <td>Result:</td><td colspan="2"><input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration</td></tr> </table> <p>AND</p> <p>2. <u>Current 1-step TB Skin Test</u></p> <table border="1"> <tr> <td></td><td>TB skin test plant</td><td>TB skin test read</td></tr> <tr> <td>Dates:</td><td></td><td></td></tr> <tr> <td>Result:</td><td colspan="2"><input type="checkbox"/> Negative <input type="checkbox"/> Positive ____mm induration</td></tr> </table> <p><u>If TB skin test result is positive:</u></p> <p>Required documents:</p> <ul style="list-style-type: none"> Attach copy of chest x-ray report, completed within the last 12 months Attach any subsequent referral/treatment with your completed Immunization - Communicable Disease Form 	1st	TB skin test plant	TB skin test read	Dates:			Result:	<input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration		2nd	TB skin test plant	TB skin test read	Dates:			Result:	<input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration			TB skin test plant	TB skin test read	Dates:			Result:	<input type="checkbox"/> Negative <input type="checkbox"/> Positive ____mm induration		<p>_____ Signature and designation of attesting MD, RN or RPN</p> <p>_____ Date</p> <div style="border: 1px dashed black; padding: 20px; text-align: center; margin-top: 20px;"> <p>OFFICE STAMP</p> </div>
1st	TB skin test plant	TB skin test read																											
Dates:																													
Result:	<input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration																												
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Dates:																													
Result:	<input type="checkbox"/> Negative <input type="checkbox"/> Positive ____mm induration																												



Name:

Student ID #:

Program:

Tuberculosis Skin Testing Continued

Option	Requirement	Authorization									
OPTION #3	Documentation Required										
For students who: <ul style="list-style-type: none">Have received a previous positive TB skin test result	<p>Provide documentation of previous positive test. No further skin testing is required if a student has had a previous positive TB skin test result.</p> <p>Please refer to TB skin testing guidelines from the Public Health Agency of Canada.</p> <p>1. <u>Previous positive TB skin test result</u></p> <table><tr><td></td><td>TB skin test plant</td><td>TB skin test read</td></tr><tr><td>Dates:</td><td></td><td></td></tr><tr><td>Result:</td><td colspan="2"><input type="checkbox"/> Positive _____ mm induration</td></tr></table> <p>AND</p> <p>2. <u>Required Documents</u></p> <ul style="list-style-type: none">Attach copy of the chest x-ray report, completed within the last 12 monthsAttach any subsequent referral/treatment received in relation to the positive TB test result		TB skin test plant	TB skin test read	Dates:			Result:	<input type="checkbox"/> Positive _____ mm induration		<p>_____ Signature and designation of attesting MD, RN or RPN</p> <p>_____ Date</p> <p>OFFICE STAMP</p>
	TB skin test plant	TB skin test read									
Dates:											
Result:	<input type="checkbox"/> Positive _____ mm induration										



Name:

Student ID #:

Program:

Varicella (Chicken Pox) Vaccine

Please complete: Option 1 or 2.

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



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 Canadian Immunization Guidelines as needed.	
OPTION #1	Immunization	
	Date of 1 st MMR dose: _____ Date of 2 nd MMR dose: _____	_____ Signature and designation of attesting MD, RN or RPN _____ Date
OPTION #2	Serology	
	Date of test: _____ Result (attach report): 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:

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 Canadian Immunization Guidelines as needed.</p> <p>1. <u>Immunization-Hepatitis B (2 or 3 dose series)</u></p> <table border="1"><thead><tr><th></th><th>1st Dose</th><th>2nd Dose</th><th>3rd Dose</th></tr></thead><tbody><tr><td>Dates:</td><td></td><td></td><td></td></tr></tbody></table> <p>AND</p> <p>2. <u>Hepatitis B antibody titre (HBsAb)</u></p> <p>Date of titre: _____</p> <p>Result (attach report): <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p> <p>If required, repeat HB vaccine series:</p> <table border="1"><thead><tr><th></th><th>1st Dose</th><th>2nd Dose</th><th>3rd Dose</th></tr></thead><tbody><tr><td>Dates:</td><td></td><td></td><td></td></tr></tbody></table> <p>THEN</p> <p>3. <u>Repeat HBsAb</u></p> <p>Date of test: _____</p> <p>Result (attach report): <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p>		1 st Dose	2 nd Dose	3 rd Dose	Dates:					1 st Dose	2 nd Dose	3 rd Dose	Dates:				<p>_____ Signature and designation of attesting MD, RN or RPN</p> <p>_____ Date</p> <p>_____ <i>OFFICE STAMP</i></p>
	1 st Dose	2 nd Dose	3 rd Dose														
Dates:																	
	1 st Dose	2 nd Dose	3 rd Dose														
Dates:																	



Name:

Student ID #:

Program:

Tetanus/Diphtheria/Pertussis/Polio (Tdap,IPV) Vaccine

Please complete: Option 1 or 2.

Option	Requirement	Authorization									
	<p>Documented proof of a primary series is required, or an adult catch-up series will be needed.</p> <p>Four doses of IPV completes the primary series. A booster dose of Pertussis is required for all adults.</p> <p>Please refer to the Canadian Immunization Guidelines as needed.</p>										
OPTION #1	Immunization										
	<p>Attach documented proof of a primary series</p> <p>Polio primary series: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent boosters:</p> <table><thead><tr><th></th><th>Date</th><th>Vaccine Type</th></tr></thead><tbody><tr><td>IPV</td><td></td><td></td></tr><tr><td>Tdap</td><td></td><td></td></tr></tbody></table>		Date	Vaccine Type	IPV			Tdap			<p>_____ Signature and designation of attesting MD, RN or RPN</p> <p>_____ Date</p>
	Date	Vaccine Type									
IPV											
Tdap											
OPTION #2	Adult Catch-up Series										
	<table><tbody><tr><td>Dose:</td><td>1st (Tdap+IPV)</td><td>2nd (Td+IPV)</td><td>3rd (Td+IPV)</td></tr><tr><td>Dates:</td><td></td><td></td><td></td></tr></tbody></table>	Dose:	1 st (Tdap+IPV)	2 nd (Td+IPV)	3 rd (Td+IPV)	Dates:				<p>_____ <i>OFFICE STAMP</i></p>	
Dose:	1 st (Tdap+IPV)	2 nd (Td+IPV)	3 rd (Td+IPV)								
Dates:											



Name:

Student ID #:

Program:

Meningococcal Vaccine

Please complete Immunization.

Requirement	Authorization
<p>Documented proof of receiving the Quadrivalent meningococcal vaccine (MenC-A,C,Y,W-135) vaccine is required. A booster dose should be administered if primary dose was administered greater than 5 years prior. Meningococcal B vaccine (4CMenB) vaccine is highly recommended.</p> <p>Please refer to the Canadian Immunization Guidelines as needed.</p> <p><u>MenC-A,C,Y,W-135</u></p> <p>Date of primary dose: _____</p> <p>Date of booster dose (if required): _____</p> <p><u>4CMenB</u></p> <p>Date of primary dose: _____</p>	<p>_____ Signature and designation of attesting MD, RN or RPN</p> <p>_____ Date</p> <p>_____ <i>OFFICE STAMP</i></p>

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):