

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: The Immunization – Communicable Disease Form must be completed by a license medical doctor or nurse practitioner.

Steps to follow:

1. Download this immunization form.
2. Ask your healthcare provider to:
 - Complete all sections of the Form
 - Provide you with proof of immunizations and/or laboratory blood results for identified sections
 - Sign and date at the end of each section
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 required documents*. 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.**

* Required documents –

- ✓ Immunization-Communicable Disease Form
- ✓ Immunization records
- ✓ Laboratory Reports

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.

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)																			
<p>For students who:</p> <ul style="list-style-type: none"> Have never received a 2-step TB skin test <p>OR</p> <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"> <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 colspan="3">Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive ____ mm induration</td> </tr> </table> <p>THEN</p> <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 colspan="3">Result: <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 and 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			<p>_____ Signature and designation of attesting MD or RN</p> <p>_____ Date</p> <div style="border: 1px dashed black; height: 150px; margin-top: 20px; display: flex; align-items: center; justify-content: center;"> <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																				
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 con't

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 and 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 or RN</p> <p>_____ Date</p> <div style="border: 1px dashed black; padding: 20px; text-align: center; margin-top: 20px;"> <p>OFFICE STAMP</p> </div>
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Name:	
Student ID #:	
Program:	

Tuberculosis Skin Testing con't

Option	Requirement	Authorization									
OPTION #3											
Documentation Required											
<p>For students who:</p> <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 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"/> 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 months Attach 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 or RN</p> <p>_____ Date</p> <div style="border: 1px dashed black; height: 150px; margin-top: 20px; text-align: center; padding-top: 50px;">OFFICE STAMP</div>
	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
	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 Canadian Immunization Guidelines as needed.	
OPTION #1	Immunization	
	Date of 1 st varicella dose: _____ Date of 2 nd varicella dose: _____	_____ Signature and designation of attesting MD or RN _____ Date
OPTION #2	Serology	
	Date of test: _____ Result (attach report): <input type="checkbox"/> Negative <input type="checkbox"/> Positive <u>If serology negative/indeterminate:</u> Date of 1 st varicella dose: _____ Date of 2 nd varicella dose (if required): _____	<div>OFFICE STAMP</div>



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 or RN _____ 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><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><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 or RN</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 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 Canadian Immunization Guidelines as needed.									
OPTION #1	Immunization									
	Attach documented proof of a primary series Date of recent booster: _____ Vaccine type: _____	_____ Signature and designation of attesting MD or RN _____ Date								
OPTION #2	Adult Catch-up Series									
	<table><tr><td>Dose:</td><td>1st (Tdap)</td><td>2nd (TD)</td><td>3rd (TD)</td></tr><tr><td>Dates:</td><td></td><td></td><td></td></tr></table>	Dose:	1 st (Tdap)	2 nd (TD)	3 rd (TD)	Dates:				<div>OFFICE STAMP</div>
Dose:	1 st (Tdap)	2 nd (TD)	3 rd (TD)							
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):	
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