

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 supporting documentation to immunizations@sl.on.ca. An SLC Campus Health Centre nurse will review your submission and contact you to confirm immunization completion or to offer an appointment to ensure timely completion.

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 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).



**Student Wellness
Campus Health Centre**



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>Result:</td> <td colspan="2"> <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>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		<hr/> <p>Signature and designation of attesting MD, NP, RN or RPN</p> <hr/> <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																		
	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" data-bbox="388 766 1109 884"> <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" data-bbox="388 993 1109 1110"> <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" data-bbox="388 1308 1109 1425"> <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		<hr/> <p>Signature and designation of attesting MD, NP, RN or RPN</p> <hr/> <p>Date</p> <div data-bbox="1138 1071 1537 1398" style="border: 1px dashed black; padding: 20px; text-align: 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																												
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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						
<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" data-bbox="505 806 1086 873"> <tr> <td>TB skin test plant</td> <td>TB skin test read</td> </tr> </table> <p>Dates: <table border="1" data-bbox="505 873 1086 949"><tr><td></td><td></td></tr></table></p> <p>Result: <input type="checkbox"/> Positive _____mm induration</p> <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			<p>_____ Signature and designation of attesting MD, NP, RN or RPN</p> <p>_____ Date</p> <p style="text-align: center;">OFFICE STAMP</p>
TB skin test plant	TB skin test read					



Name:	
Student ID #:	
Program:	

Varicella (Chicken Pox) Vaccine

Please complete: Option 1 or 2

Option	Requirement	Authorization
	<p>Documentation of two varicella vaccines is required.</p> <p>If no records are available, bloodwork to determine immunity to varicella can be completed.</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, NP, RN or RPN</p> <p>_____ Date</p>
OPTION #2	Serology	
	<p>Date of test: _____</p> <p>Result (attach report): <input type="checkbox"/> Not immune <input type="checkbox"/> Immune</p> <p><u>If serology not immune:</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
	<p>Documentation of two MMR vaccines is required.</p> <p>If no records are available, bloodwork to determine immunity to MMR can be completed.</p> <p>Please refer to the Canadian Immunization Guidelines as needed.</p>	
OPTION #1	Immunization	
	<p>Date of 1st MMR dose: _____</p> <p>Date of 2nd MMR dose: _____</p>	<p>Signature and designation of attesting MD, NP, RN or RPN</p> <p>_____</p>
OPTION #2	Serology	Date
	<p>Date of test: _____</p> <p>Result (attach report):</p> <p>Measles: <input type="checkbox"/> Not immune <input type="checkbox"/> Immune</p> <p>Mumps: <input type="checkbox"/> Not immune <input type="checkbox"/> Immune</p> <p>Rubella: <input type="checkbox"/> Not immune <input type="checkbox"/> Immune</p> <p><u>If serology not immune:</u></p> <p>Date of MMR booster: _____</p>	<p>_____</p> <p style="text-align: center;"><i>OFFICE STAMP</i></p>



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" data-bbox="272 814 1070 970"> <tr> <td></td> <td>1st Dose</td> <td>2nd Dose</td> <td>3rd Dose</td> </tr> <tr> <td>Dates:</td> <td></td> <td></td> <td></td> </tr> </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"/> Not immune <input type="checkbox"/> Immune</p> <p>If required, repeat HB vaccine series:</p> <table border="1" data-bbox="272 1314 1070 1470"> <tr> <td></td> <td>1st Dose</td> <td>2nd Dose</td> <td>3rd Dose</td> </tr> <tr> <td>Dates:</td> <td></td> <td></td> <td></td> </tr> </table> <p>THEN</p> <p>3. <u>Repeat HBsAb</u></p> <p>Date of test: _____</p> <p>Result (attach report): <input type="checkbox"/> Not immune <input type="checkbox"/> Immune</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, NP, RN or RPN</p> <p>_____ Date</p> <div data-bbox="1109 1249 1515 1587" style="border: 1px dashed black; padding: 20px; text-align: center;"> <p>OFFICE STAMP</p> </div>
	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 complete 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>	<p>_____ Signature and designation of attesting MD, NP, RN or RPN</p> <p>_____ Date</p>								
OPTION #1	Immunization									
	<p>Attach documented proof of tetanus, diphtheria, pertussis, and polio primary series.</p> <p>Date of recent booster (if required): _____</p> <p>Vaccine type: _____</p>									
OPTION #2										
	<table border="1"> <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> </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:										

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):