Student Wellness
Campus Health Centre | St. Lawrence College

Program Immunization– Communicable Disease Form

Students entering the Select Program 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	Cornwall	Kingston
Phone: 613-345-0660 ext. 5524	Phone: 613-933-6080 ext. 5525	Phone: 613-544-5400 ext. 5521
Email: HealthCentreB@sl.on.ca	Email: HealthCentreC@sl.on.ca	Email: HealthCentreK@sl.on.ca
Room 250B	Room A111	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).

CLEAR FORM

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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: • Have never received a 2-step TB skin test **OR** • Are unable to provide documentation of receiving a 2-step TB skin test	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). Please refer to TB skin testing guidelines from the **Public Health Agency of Canada**. **1st** | TB skin test plant | TB skin test read Dates: | | | Result: ☐ Negative ☐ Positive ___ mm induration ***THEN*** **2nd** | TB skin test plant | TB skin test read Dates: | | | Result: ☐ Negative ☐ Positive ___ mm induration If TB skin test result is **positive**: Required documents: • 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	Signature and designation of attesting MD, NP, RN or RPN Date *OFFICE STAMP*

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Name:	
Student ID #:	
Program:	

Tuberculosis Skin Testing Continued

Option	Requirement	Authorization
OPTION #2	**TB Skin test (1-step)**	
For students who: • Have documentation of a previous 2-step TB test with a **negative result** **AND** • Require an up to date 1-step TB skin test	A 1-step TB skin test is required for students who have completed a prior 2-step TB skin test. Please refer to TB skin testing guidelines from the **Public Health Agency of Canada**. ***1.*** **Provide results of previous 2-step TB skin test** **1st** TB skin test plant / TB skin test read Dates: Result: ☐ Negative ☐ Positive ___ mm induration **2nd** TB skin test plant / TB skin test read Dates: Result: ☐ Negative ☐ Positive ___ mm induration ***AND*** ***2.*** **Current 1-step TB Skin Test** TB skin test plant / TB skin test read Dates: Result: ☐ Negative ☐ Positive ___mm induration If TB skin test result is **positive**: Required documents: • 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	_____ Signature and designation of attesting MD, NP, RN or RPN _____ Date *OFFICE STAMP*

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Name:	
Student ID #:	
Program:	

Tuberculosis Skin Testing Continued

Option	Requirement	Authorization
OPTION #3	**Documentation Required**	
For students who: • Have received a **previous positive** TB skin test result	Provide documentation of previous positive test. No further skin testing is required if a student has had a previous positive TB skin test result. Please refer to TB skin testing guidelines from the **Public Health Agency of Canada**. ***1.*** **Previous positive TB skin test result** TB skin test plant / TB skin test read Dates: Result: ☐ Positive _____ mm induration ***AND*** ***2.*** **Required Documents** • 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	Signature and designation of attesting MD, NP, RN or RPN Date *OFFICE STAMP*

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Name:	
Student ID #:	
Program:	

Varicella (Chicken Pox) Vaccine

Please complete: Option 1 or 2

Option	Requirement	Authorization
	Documentation of two varicella vaccines is required. If no records are available, bloodwork to determine immunity to varicella can be completed. Please refer to the **Canadian Immunization Guidelines** as needed.	
OPTION #1	Immunization	
	Date of 1st varicella dose: _____ Date of 2nd varicella dose: _____	_____ Signature and designation of attesting MD, NP, RN or RPN _____ Date
OPTION #2	Serology	
	Date of test: _____ Result (**attach report**): ☐ Not immune ☐ Immune If serology not immune: Date of 1st varicella dose: _____ Date of 2nd varicella dose (if required): _____	*OFFICE STAMP*

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Name:	
Student ID #:	
Program:	

Measles Mumps Rubella (MMR) Vaccine

Please complete: Option 1 or 2

Option	Requirement	Authorization
	Documentation of two MMR vaccines is required. If no records are available, bloodwork to determine immunity to MMR can be completed. Please refer to the **Canadian Immunization Guidelines** as needed.	
OPTION #1	Immunization	
	Date of 1st MMR dose: _____ Date of 2nd MMR dose: _____	_____ Signature and designation of attesting MD, NP, RN or RPN _____ Date
OPTION #2	Serology	
	Date of test: _____ Result (**attach report**): Measles: ☐ Not immune ☐ Immune Mumps: ☐ Not immune ☐ Immune Rubella: ☐ Not immune ☐ Immune If serology not immune: Date of MMR booster: _____	*OFFICE STAMP*

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Name:	
Student ID #:	
Program:	

Hepatitis B (HB) Vaccine

Complete Immunization and Serology.

Requirement	Authorization
Documented proof of Hepatitis B immunity through immunization records and antibody testing is required. If serology shows insufficient immunity, please repeat series as appropriate then re-titre. Please refer to the **Canadian Immunization Guidelines** as needed.	
1. **Immunization-Hepatitis B (2 or 3 dose series)** Dates: 1st Dose ____ 2nd Dose ____ 3rd Dose ____	Signature and designation of attesting MD, NP, RN or RPN
AND	
2. **Hepatitis B antibody titre (HBsAb)** Date of titre: _____ Result (**attach report**): ☐ Not immune ☐ Immune	Date
If required, repeat **HB vaccine series**: Dates: 1st Dose ____ 2nd Dose ____ 3rd Dose ____	OFFICE STAMP
THEN	
3. **Repeat HBsAb** Date of test: _____ Result (**attach report**): ☐ Not immune ☐ Immune	

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Name:	
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Program:	

Tetanus/Diphtheria/Pertussis/Polio (Tdap,IPV) 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. Four doses of IPV completes the primary series. 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 tetanus, diphtheria, pertussis, and polio **primary series**. Date of boosters if required:	Signature and designation of attesting MD, NP, RN or RPN Date *OFFICE STAMP*
OPTION #2	Adult Catch-up Series	

	Date	Vaccine Type
IPV		
Tdap		

Dose:	1st (Tdap+IPV)	2nd (Td+IPV)	3rd (Td+IPV)
Dates:			

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Name:	
Student ID #:	
Program:	

Meningococcal Vaccine

Please complete Immunization.

Requirement	Authorization
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. Serogroup B meningococcal vaccine (4CMenB or MenB-fHBP) is highly recommended. Please refer to the **Canadian Immunization Guidelines** as needed. **MenC-A,C,Y,W-135** Date of primary dose: _____ Date of booster dose (if required): _____ **Serogroup B Meningococcal (highly recommended)** Date of primary dose 1: _____ Date of primary dose 2: _____	_____ Signature and designation of attesting MD, NP, RN or RPN _____ Date *OFFICE STAMP*

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):	