



1600 West Bank Drive, Peterborough, ON Canada K9L 0G2
705 -748-1099, nursing@trentu.ca

Trent Fleming School of Nursing Immunization and Communicable Disease Form

Student Name:

Student ID#:

Trent email:

Phone Numbers:

Note to Healthcare Providers

Thank you for your cooperation with the immunization process for candidates admitted to the Trent/Fleming School of Nursing. The Non- Academic Requirements for BScN students have been developed to reflect the immunization and screening requirements of the various agencies where the students may attend clinical practice. Failure to complete the form and provide documentation of the required serology results will prevent the student from attending clinical and may result in deregistration from the BScN program. Please note all information must be transcribed to this form, as supporting documents alone will not be accepted.

Healthcare provider professional stamp (or name and address of clinic where form was completed)

Date:

HCP Signature:



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Part 1: Tuberculosis Screening

Documentation of a baseline two-step Mantoux skin test (TB) is required for all new students. Thereafter students will be required to submit an annual one-step Mantoux skin test (TB).

Section A:

Only complete this section if the student has never received a two-step Mantoux skin test (TB) OR does not have documentation of their two-step Mantoux skin test (TB).

- Students who have never completed a TB test must complete a baseline two-step Mantoux skin test.
- Step two (2) must be administered 7-28 days after step one (1) and all results must be recorded in (mm).
- Students who have received a BCG vaccination are NOT exempt from Mantoux testing.

Baseline Two-Step Mantoux Test Information:

Step #1

Date Given (mm/dd/yyyy):

Date Read (mm/dd/yyyy):

Induration Results (mm):

HCP Initials:

Step #2 (must be completed within 7-28 days after Step #1)

Date Given (mm/dd/yyyy):

Date Read (mm/dd/yyyy):

Induration Results (mm):

HCP Initials:

Section B:

Only complete this section if the student has previously received and has documentation of a negative two-step Mantoux skin test (TB).

- Students must submit evidence of their previous negative two-step Mantoux skin test (TB)
- Please complete the information below.

Baseline Two-Step Mantoux Test Information:



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Step #1

Date Given (mm/dd/yyyy):

Date Read (mm/dd/yyyy):

Induration Results (mm):

HCP Initials:

Step #2 (must be completed within 7-28 days after Step #1)

Date Given (mm/dd/yyyy):

Date Read (mm/dd/yyyy):

Induration Results (mm):

HCP Initials:

In addition to submitting evidence of a previous two-step Mantoux skin test (TB) students must also complete an annual one-step Mantoux skin test (TB).

Annual One-Step Mantoux Test Information:

Step #1

Date Given (mm/dd/yyyy):

Date Read (mm/dd/yyyy):

Induration Results (mm):

HCP Initials:

Section C:

Only complete this section if the student has previously received and has documentation of a positive two-step or one-step Mantoux skin test.

- Students who have had a positive Mantoux skin test (TB) should not receive further Mantoux testing.
- A chest x-ray is **required every two (2) years** and the report must be enclosed with this package.
- The responsibility for follow-up lies with the Healthcare Provider as per OHA/OMA Communicable Disease Surveillance Protocols.
- Please complete the information below as evidence of the student's previous **positive** Mantoux skin test (TB).



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Positive Baseline Two-Step or One-step Mantoux Test Information:

Step #1

Date Given (mm/dd/yyyy):

Date Read (mm/dd/yyyy):

Induration Results (mm):

HCP Initials:

Step #2 (must be completed within 7-28 days after Step #1)

Date Given (mm/dd/yyyy):

Date Read (mm/dd/yyyy):

Induration Results (mm):

HCP Initials:

Questions:

1. Is the chest x-ray enclosed with this package (required)?
2. Date of chest x-ray (mm/dd/yyyy)
3. Result of the chest x-ray:
4. Did the student receive prophylactic treatment (INH)?
5. Has the student had BCG Vaccination?
6. Does the student have any current signs or symptoms of active TB?

Part 2: COVID-19 Vaccine Series

COVID-19 primary series plus one booster is mandatory. Proof of COVID-19 vaccination is required.

First Dose

Date Given (mm/dd/yyyy)

HCP Initials:



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Second Dose

Date Given (mm/dd/yyyy)

HCP initials:

Booster Doses

Date Given (mm/dd/yyyy)

HCP Initials:

Additional Dose

Date Given (mm/dd/yyyy)

HCP Initials:

Part 3: Red Measles, Mumps, Rubella (German Measles)-MMR

Serology results for MMR must be completed. Results must be documented below and copies of the blood work results must be submitted.

If Serology results indicate Non-Immune or Indeterminate, documentation of two vaccinations of MMR is required and one of these vaccinations must be a booster dose (vaccination given post blood work results).

Healthcare providers please fill out the dates and indicate immune or non-immune. Please attach a copy of the blood work results.

Communicable Disease Information:

Measles

Date of Serology Results (mm/dd/yyyy):

Immune or Non-immune:

Mumps

Date of Serology Results (mm/dd/yyyy):

Immune or Non-immune:

Rubella

Date of Serology Results (mm/dd/yyyy):

Immune or Non-immune:



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Please provide two (2) vaccination dates below, if blood work results were non-immune or indeterminate. One of these vaccinations must be a booster dose (vaccination given post blood work).

MMR Vaccination Dates:

1st Vaccination Date (mm/dd/yyyy):

2nd Vaccination Date (mm/dd/yyyy):

Part 4: Varicella (Chicken Pox or Shingles)

The student must show proof of two (2) doses of Varicella Vaccinations completed at least one month apart or Serology results for Varicella showing immunity. If providing Serology results, the Healthcare Provider must attach a copy of the results (History of chicken pox is not sufficient).

Healthcare providers please fill out the dates and indicate immune or non-immune. Please attach a copy of the blood work results.

Communicable Disease Information:

Varicella

Date of Serology Results (mm/dd/yyyy):

Immune or Non-immune:

Please provide two (2) Varicella vaccination dates below, if blood work results were non-immune or indeterminate. One of these vaccinations must be a booster dose (vaccination given post blood work).

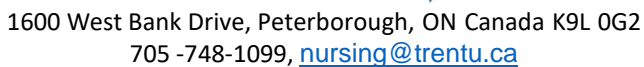
Varicella Vaccination Dates:

1st Vaccination Date (mm/dd/yyyy):

2nd Vaccination Date (mm/dd/yyyy):

Part 5: Diphtheria, Tetanus, Polio

Documentation of completed primary series is required. Records of childhood vaccinations can be obtained by calling the Public Health Department located where you last attended school. Routine Childhood Immunizations include all three of these vaccines. If the student did not receive childhood vaccines, please refer to the required schedule to start an un-immunized adult series.



a)	Received Routine childhood immunizations:	Yes	No
b)	Date of most recent Tdap/Td Booster dose (mm/dd/yyyy) *Must be within the last 10 years*		

3rd Vaccination Date (mm/dd/yyyy):

Immune or Non-Immune:



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Section B:

If the student is non-immune in section A please complete section B.

If the student is non-immune to Hepatitis B, a booster dose or a completed second series of vaccinations may be required. Blood work results post booster, or second series must be enclosed and can be done one month after final dose.

Hepatitis B Vaccination Dates:

1st Vaccination Date (mm/dd/yyyy):

2nd Vaccination Date (mm/dd/yyyy):

3rd Vaccination Date (mm/dd/yyyy):

Hepatitis B (anti-HBs/HBsAB) blood work:

Date of Serology Results (mm/dd/yyyy):

Immune or Non-Immune:

After having received a second series of Hepatitis B vaccine and having post vaccination blood work, the student still does not show immunity and is a non-responder, therefore, will not require further immunizations.

HCP Signature:

TRENT/FLEMING SCHOOL OF
NURSING

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**Authorization to Release Healthcare/Police
Information**

Student's Name:

Previous Name (if applicable):

Student ID#:

Trent Email:

I request and authorize the Trent/Fleming School of Nursing to release healthcare information and results of my criminal record check with vulnerable sector screening on my behalf to clinical placement agencies, as necessary, to meet with placement requirements.

Please initial beside each statement below to show that you have read and understood each declaration:

Healthcare information relating to the following: measles, mumps, rubella, varicella, hepatitis A & B, tuberculosis screening, chest x-ray reports, tetanus, diphtheria, pertussis, polio, influenza vaccination, childhood immunization records and titre serology reports.

Initial:

Police check information including vulnerable sector screening: I am aware that if I have a positive police record search (meaning convictions under the Criminal Code of Canada for which a pardon has not been granted, or charges that are ongoing or have been withdrawn, or any sexual offences under the Criminal Records act), that the Trent/Fleming School of Nursing will be required to disclose this information to all clinical placement agencies.

Initial:

I understand the purpose for disclosing my health information to a clinical placement agency. I understand that I can refuse to sign this consent form.

Initial:

Please Print Clearly:

Student Name:

Address:

Phone #:

Signature:

Date:

Witness Name:

Address:

Phone #:

Signature:

Date:

This authorization form is valid for all clinical practice placements while enrolled in the Trent/Fleming School of Nursing program.