

Communicable Disease Screening Protocol

PLEASE READ CAREFULLY: Remember – Being ready is your responsibility!

Surname:		First Name:		Initial:
Address:		City:	Postal Code:	
Phone:	Cell Phone:	Email:		
Date of Birth:	Health Card Number:	Health Card Check:	<u>ALLERGIES:</u>	
Campus:	Program:	Mohawk ID#	ID check:	

Please have the form completed by the nurse at one of the following locations – phone for office hours:

Health Services, Fennell Campus
135 Fennell Avenue West, Room C109
Hamilton, ON L8N 3T2
905-575-2084
905-575-2416 fax

Health Services, Institute for Applied Health Sciences
1400 Main Street West, Room 303
Hamilton, ON L8S 1C7
905-540-4247 ext. 26750
905-528-0517 fax

General Instructions:

Computerized records of childhood vaccines can be obtained by calling your Public Health Department. Contact information for all Ontario Public Health Departments can be found on the following web site:

www.health.gov.on.ca/english/public/contact/phu/phu_mn.html. ATTACH COPIES OF YOUR VACCINATION RECORDS.

ATTACH COPIES OF ALL LAB RESULTS. Placement agencies have reserved the right to refuse access to students who do not meet their immunization testing requirements. CE Paid

HEPATITIS B VACCINE: If you have not already been vaccinated for Hepatitis B, you may elect to receive the vaccine at Mohawk College Health Services at a special rate. Blood test for post vaccination anti-HBs antibody titres to be done at least one month after the initial series or booster is completed.

Primary Series:

Date #1 _____ Date #2 _____ Date #3 _____ Immunization Record

Hepatitis B immune status: Date: _____ Immune Non-Immune

If initiating primary series or if Non-Immune: document series or booster(s) below.

Enerix

Recombivax

Paid

	Date	Site	Dose	Lot #	Signature	titre date	Post booster titre
#1 Paid <input type="checkbox"/>		Deltoid L R					<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune
#2 Paid <input type="checkbox"/>		Deltoid L R					<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune
#3 Paid <input type="checkbox"/>		Deltoid L R					<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune
# Paid <input type="checkbox"/>		Deltoid L R					<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune

Last Name: _____	First Name: _____	Date of Birth: _____				
Allergies: _____						
MEASLES, MUMPS, RUBELLA (MMR): Documented history of two doses of MMR on or after 1 st birthday or blood work demonstrating immunity.						
Date of 1 st MMR: _____	<input type="checkbox"/> Imm Record	Or Signature: _____				
Date of 2 nd MMR: _____	<input type="checkbox"/> Imm Record	Or Signature: _____				
Date of Measles: _____	<input type="checkbox"/> Imm Record					
Date _____	Measles <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive or Indeterminate					
_____	Mumps <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive or Indeterminate					
_____	Rubella <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive or Indeterminate					
If you are not immune, immunization is required. Do not give until after T.B. testing is completed.						
Date given: _____	Signature _____					
Post booster titre date: _____	<input type="checkbox"/> Reactive	<input type="checkbox"/> Non-Reactive or Indeterminate				
Date given: _____	Signature _____					
VARICELLA IMMUNITY: Past history of infection with chicken pox: Yes <input type="checkbox"/> No further testing required. No <input type="checkbox"/> Varicella immune status required.						
Date: _____	<input type="checkbox"/> Reactive	<input type="checkbox"/> Non-Reactive				
Record of Vaccination or if non-reactive give Varivax: Do not give Varivax until after T.B. skin testing is completed. Give at the same time as MMR. Varivax doses are <u>six</u> weeks apart.						
Varivax #1: Date: _____	Signature _____					
Varivax #2: Date: _____	Signature _____					
PERTUSSIS: If no documentation of adolescent or adult dose received previously, a single dose of Tdap (Adacel) is required.						
Confirm primary series: Yes <input type="checkbox"/> No <input type="checkbox"/>	Vaccine: _____	Date: _____				
	Signature _____					
TUBERCULOSIS:						
Past History of Positive T.B. Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach documentation and copy of chest x-ray result.						
<ul style="list-style-type: none"> • Everyone requires a two-step T.B. test. If you have ever had a two-step T.B. test in the past, please provide documentation. NOTE: All Health Science Students <u>must</u> have a yearly T.B. update. • The two-step skin test is conducted as follows: An initial skin test (5TU PPD) is given. The test is read 48-72 hours later. If this test is negative, a second test is given in the opposite arm at least one week and no more than three weeks after the first. The results of the second test should be used as the baseline test in determining treatment and follow-up of these persons. ▪ Do not give MMR or Varivax until after T.B. testing is completed. 						
2- STEP TUBERCULIN SKIN TEST:						
Site	Test Date	Lot #	Signature	Date Read	mm induration	Signature
1	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
Positive T.B. skin test : Chest X-Ray			Date: _____	Result: _____	No further T.B. skin tests	

References: [Canadian Immunization Guide](#), [Canadian Tuberculosis Standards](#), [OHA/OMA Guidelines](#)

I state that the above information is accurate. I understand and agree that this information and related laboratory and x-ray results may be used for or given to the placement or place of employment.

Student Signature: _____ Date: _____

Approved by Mohawk College RN/RPN: _____ Date: _____