

# Communicable Disease Screening Protocol

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

Surname:		First Name:		Initial:
Address:		City:		
Postal Code:	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:

**Fennell Campus**  
Room C109  
905-575-2084  
905-575-2416 fax

**Institute for Applied Health Sciences**  
Room 303  
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](http://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 non immune initiate booster or boosters. Document below.

Engerix  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

PLEASE TURN OVER →

Last Name: _____	First Name: _____	Date of Birth: _____
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**ALLERGIES:**

**MEASLES, MUMPS, RUBELLA (MMR):** Documented history of two doses of MMR on or after 1<sup>st</sup> birthday or blood work demonstrating immunity.

**If born PRIOR to 1970 consider immune to Measles: Yes**       **Test for Rubella & Mumps: Yes**

Date of 1<sup>st</sup> MMR: \_\_\_\_\_  Imm Record      Date of Measles: \_\_\_\_\_  Imm Record

Date of 2<sup>nd</sup> MMR: \_\_\_\_\_  Imm Record

Date _____	Measles <input type="checkbox"/>	Reactive <input type="checkbox"/>	Non-Reactive or Indeterminate <input type="checkbox"/>
_____	Mumps <input type="checkbox"/>	Reactive <input type="checkbox"/>	Non-Reactive or Indeterminate <input type="checkbox"/>
_____	Rubella <input type="checkbox"/>	Reactive <input type="checkbox"/>	Non-Reactive or Indeterminate <input type="checkbox"/>

**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: \_\_\_\_\_  Reactive       Non-Reactive or Indeterminate

Date given: \_\_\_\_\_ Signature \_\_\_\_\_

**VARICELLA IMMUNITY:** Past history of infection with chicken pox: Yes  No further testing required.

No  Varicella immune status required.

Date: \_\_\_\_\_  Reactive       Non-Reactive

**If non-reactive give Varivax: Do not give Varivax until after T.B. skin testing is completed. May be given at the same time as MMR or give Varivax and MMR one month apart.**

Varivax #1: Date: \_\_\_\_\_ Signature \_\_\_\_\_

Varivax #2: Date: \_\_\_\_\_ Signature \_\_\_\_\_

**TETANUS:** Tetanus booster doses are given at 10 year intervals, but may be given if five years have elapsed since the last dose. Give Tdap (Adacel) at time of next booster if not previously received.

Confirm primary series: Yes  No  Vaccine: \_\_\_\_\_ Date: \_\_\_\_\_

Signature \_\_\_\_\_

**TUBERCULOSIS:**

**Past History of Positive T.B. Yes  No  If yes, please attach documentation and copy of chest x-ray result.**

- Everyone requires a two-step TB test. If you have ever had a two-step TB test in the past, please provide documentation. NOTE: All Health Science Students must have a yearly TB 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 TB testing is completed.**

**2- STEP TUBERCULIN SKIN TEST:**

Site	Test Date	Lot #	Signature	Date Read	mm induration	Signature
1	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

**Positive TB skin test : Chest X-Ray** Date: \_\_\_\_\_ Result: \_\_\_\_\_ **No further TB skin tests**

References: Canadian Immunization Guide, 2006, Canadian Tuberculosis Standards, 2007, OHA/OMA Guidelines (09-10)

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: \_\_\_\_\_

Copy to Student:  2<sup>nd</sup> copy: