BScN Scholar Practitioner Program
Communicable Disease Screening Form

Student Name: _____ **Student Number**: _____

Date of Birth: _____

Student Authorization:

I have read and understand this information. I give my consent that the information on this form is accurate and true and may be shared as required with Nipissing University, Clinical Faculty, Administrative/Support Staff, and Placement Agencies.

Signature: _____ **Date:** _____

Dear Student,

The BScN Scholar Practitioner Program includes clinical placements as an essential component of the program. In order to protect yourself and the patients you will be interacting with, you must complete all required immunizations upon admission and annually as indicated. You may also be required to update any necessary immunizations during your enrollment in the program. It is your responsibility to carefully review the following instructions and ensure that you comply with all of the requirements.

1. **General Instructions**
    - Please ensure your personal health care provider understands that the form must be completed as indicated. Every page and section **MUST** be filled out. Failure to comply may lead to repeat testing/immunization. Incomplete documents will be discarded.
    - Agencies have reserved the right to refuse access to students who do not meet their clinical placement requirements. Agencies may also have additional requirements that are separate from the School of Nursing requirements.
    - Documents that will be accepted as proof of immunization include the provincial Immunization Record, documentation signed by your health care provider (Registered Nurse, Registered Practical Nurse, Nurse Practitioner or Physician), or laboratory evidence (report). ***All information from the aforementioned records must be recorded on your form.***
    - Forms can be filled out by the student and then approved and endorsed by a qualified healthcare provider **OR** completed by a qualified healthcare provider (R.N., R.P.N., N.P., or Physician). Please ensure document is signed and designation of healthcare provider is included.
    - Failure to submit a signed and duly completed Communicable Disease Screening Form to the School of Nursing will result in ineligibility to register for clinical courses.

The completed form must be saved as a PDF and uploaded to the Clearance Website. **Students must keep their original documents.** Questions regarding these instructions, the form and/or the requirements, should be directed to the Clinical Clearance Office at 705-474-3450, ext 4579.

Kind Regards,

Jarod Cadotte

Revised June 2022

NIPISSING UNIVERSITY

Student Name: _____	**Student Number:**_____
Instructions	**Immunization/Serologic Status**

TUBERCULOSIS
Tuberculin Skin Test (TST)

Proof of a past baseline two-step Tuberculin Skin Test (TST) is mandatory in addition to a current one-step TST dated no earlier than July 1 of the clearance period.

OR

Students providing a current baseline two-step TST dated within the clearance period are not required to complete a one-step TST until the next clearance period.

Each TST should be 1-4 weeks apart. A 10mm or more induration is considered positive unless otherwise noted by your healthcare provider.

Positive Results:
If students have ever had a positive TST, they are required to submit the following documentation as part of their Communicable Disease Screening Form. **Note: Both documents 1 & 2 are required:**

1) Copy of recent chest x-ray report (x-ray must be less than 1 year old).

   AND

2) Annual TB Surveillance letter. A copy of this letter can be found on the clearance website.

Future TSTs are not required but the annual TB Surveillance letter must be completed and submitted on an **annual** basis as part of your renewal clearance package.

Note: if indicated as moderate or high risk for active TB, a new chest x-ray will be required.

Baseline Assessment
Two Step (TST) Documentation Required

Step 1 Date Given: (dd/mm/yy)_____

Step 1 Date Read: (dd/mm/yy)_____

Result/Induration: _____mm

Interpretation +/-: _____

Signature & Designation: _____

Step 2 Date Given: (dd/mm/yy)_____

Step 2 Date Read: (dd/mm/yy)_____

Result/Induration: _____mm

Interpretation +/-: _____

Signature & Designation: _____

One Step Tuberculin Skin Test (TST)

Date Given: (dd/mm/yy)_____

Date Read: (dd/mm/yy)_____

Result/Induration: _____mm

Interpretation +/-: _____

Signature & Designation: _____

Positive Result
□ Student has a history of a positive TST.
Date of positive TST: _____
**Must include chest x-ray and TB surveillance letter

Licensed Healthcare Provider Declaration:
I confirm that the information provided on this form is correct:

Name (please print): _____ Date:_____

Signature:_____ Designation:_____

Revised June 2022

Student Name: _____	Student Number:_____
Instructions	**Immunization/Serologic Status**
VARICELLA	
Students must document immunity via one of the following: Documented vaccination with 2 doses (regardless of year of birth) **OR** Documented laboratory evidence of immunity Note: If titre results are non-reactive/non-immune/indeterminate, then documentation of full vaccination is required by the School of Nursing.	**Documentation of Vaccination:** Dose #1 Date (dd/mm/yy)_____ Dose #2 Date (dd/mm/yy)_____ **OR** **Date of Titre: (dd/mm/yy)** **Antibody Titre must not be taken earlier than 1 month following completion of vaccination series** **Titre Results:** □ Reactive/Immune (+) □ Non-Reactive/Non-Immune (-)/Indeterminate **Note: If a booster has been given** Booster date (dd/mm/yy) _____
Licensed Healthcare Provider Declaration: I confirm that the information provided on this form is correct: Name (please print): _____ Date:_____ Signature:_____ Designation:_____	

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TETANUS/DIPHTHERIA	
Student Name: _____	**Student Number:_____**
Instructions	**Immunization/Serologic Status**
Students must document vaccination for Tetanus & Diphtheria annually and be vaccinated every 10 years. To meet clearance requirements, immunity cannot expire before July 1 of the following clearance cycle. It is the responsibility of the student to ensure that these boosters remain up to date after admittance into the Scholar Practitioner Program.	**Primary vaccine or date of most recent booster received within the last 10 years:** Vaccine Name: _____ Date (dd/mm/yy)_____

Licensed Healthcare Provider Declaration:

I confirm that the information provided on this form is correct:

Name (please print): _____ Date:_____

Signature:_____ Designation:_____

Revised June 2022

NIPISSING UNIVERSITY

Student Name: _____	Student Number:_____
Instructions	**Immunization/Serologic Status**

MEASLES, MUMPS, RUBELLA (MMR)

Students must document immunity via one of the following:

Documentation of vaccination with 2 doses (regardless of year of birth)

OR

Documented laboratory evidence of immunity (serologic testing/bloodwork for Measles, Mumps and Rubella).

Note: if titre results are non-reactive/non-immune/indeterminate, then documentation of full vaccination is required by the School of Nursing.

MMR Vaccination

Dose #1 Date (dd/mm/yy)_____

Dose #2 Date (dd/mm/yy)_____

OR

Titre Results

Antibody Titre must not be taken sooner than 1 month following completion of vaccination series

Measles

Date of Titre: (dd/mm/yy) _____

☐ Reactive/Immune (+)

☐ Non-Reactive/Non-Immune (-)

☐ Indeterminate

Mumps

Date of Titre: (dd/mm/yy) _____

☐ Reactive/Immune (+)

☐ Non-Reactive/Non-Immune (-)

☐ Indeterminate

Rubella

Date of Titre: (dd/mm/yy) _____

☐ Reactive/Immune (+)

☐ Non-Reactive/Non-Immune (-)

☐ Indeterminate

Note: If a booster has also been given

Vaccine Name: _____

Booster Date: (dd/mm/yy) _____

Licensed Healthcare Provider Declaration:

I confirm that the information provided on this form is correct:

Name (please print): _____ Date:_____

Signature:_____ Designation:_____

Revised June 2022

Student Name: _____	**Student Number:**_____
Instructions	**Immunization/Serologic Status**
POLIO	
Students must document immunity via one of the following: 1) Document full child series Polio vaccination. Polio vaccination consists of a 5 dose series for children under the age of 6 (child dose) and a 3 dose series if the primary series is started after the age of 7 (adult dose) **OR** 2) Document full Adult series Polio vaccination. Students who are unable to provide proof of immunization are required to complete a full adult series vaccination. **OR** 3) If you do not have proof of polio vaccination or are unsure of immunization status, a note from a Primary Healthcare provider (a Physician or Nurse Practitioner) is required verifying that full vaccination did occur, but documentation does not exist.	1) Primary Series Vaccination (Child) Dose #1 Date (dd/mm/yy)_____ Dose #2 Date (dd/mm/yy)_____ Dose #3 Date (dd/mm/yy)_____ Dose #4 Date (dd/mm/yy)_____ Dose #5 Date (dd/mm/yy)*_____ *Verify if 5th dose was not required _____(initial) **OR** 2) Primary Series Vaccination (Adult) Dose #1 Date (dd/mm/yy)_____ Dose #2 Date (dd/mm/yy)_____ Dose #3 Date (dd/mm/yy)_____ **OR** 3) Note from primary healthcare provider verifying full Polio vaccination did occur, but no records are available.
Licensed Healthcare Provider Declaration: I confirm that the information provided on this form is correct: Name (please print): _____ Date:_____ Signature:_____ Designation:_____	

Revised June 2022

Student Name: _____	Student Number:_____
Instructions	**Immunization/Serologic Status**
HEPATITIS B	
Students must provide both dates of primary series final dose and documented immunity. Students who are non-reactive (-) for anti-HBs after completing a primary Hepatitis B (HB)vaccination series are required to have a second series of HB vaccination and provide documentation of a second anti-HBs Titre no sooner than one month after completion of the second vaccination series. Students who continue to be non-reactive after a second series of HB vaccinations are considered "non- responders". A third series of HB vaccinations will not be required. Non-responders will be required to receive post-exposure prophylaxis HB immunization after any potential exposure to HB. ******Note: To be considered a non-reactive, students must provide documentation of full primary series, full repeat series as well as serological testing for both series showing they are non-reactive.******	**Dates of vaccination:** Dose #1 Date (dd/mm/yy)_____ Dose #2 Date (dd/mm/yy)_____ Dose #3 Date (dd/mm/yy)_____ **Surface Antibody Level (Anti-HBs Titre)** **Date of Titre:** (dd/mm/yy)_____ **Antibody Titre must not be taken sooner than 1 month following completion of vaccination series** □ Reactive/Immune (+) □ Non-Reactive/Non-Immune (-) **If non-reactive, student must complete full repeat series (3 doses recommended for HCPs):** Dose #1 Date (dd/mm/yy)_____ Dose #2 Date (dd/mm/yy)_____ Dose #3 Date (dd/mm/yy)_____ *Verify if 3rd dose was not required _____(initial) **Repeat Surface Antibody Level (Anti-HBs Titre)** **Antibody Titre must not be taken sooner than 1 month following completion of vaccination series** **Date of Titre:** (dd/mm/yy)_____ □ Reactive/Immune (+) □ Non-Reactive/Non-Immune (-)
Licensed Healthcare Provider Declaration: I confirm that the information provided on this form is correct: Name (please print): _____ Date:_____ Signature:_____ Designation:_____	

Revised June 2022

Student Name: _____	Student Number:_____
Instructions	**Immunization/Serologic Status**
FLU	
The flu shot is **optional**. Students who do not get the annual flu shot will be subject to agency policy, and it may impact your ability to complete clinical. If you have received the flu shot, you are encouraged to submit proof as part of your CDSF.	**Documentation of Vaccination:** Dose #1 Date (dd/mm/yy)_____ **Please check one of the following:** □ **Yes** - Flu proof is attached □ **No** - Flu proof is not attached

Licensed Healthcare Provider Declaration:

I confirm that the information provided on this form is correct:

Name (please print): _____ Date:_____

Signature:_____ Designation:_____