

## 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*

## BScN Scholar Practitioner Program Communicable Disease Screening Form – Annual Renewal

Student Name: _____	Student Number: _____
<b>Instructions</b>	<b>Immunization/Serologic Status</b>
<b>TUBERCULOSIS Tuberculin Skin Test (TST)</b>	
<p>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.</p> <p><b>OR</b></p> <p>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.</p> <p>Each TST should be 1-4 weeks apart. A 10mm or more induration is considered positive unless otherwise noted by your healthcare provider.</p> <p><b>Positive Results:</b> If students have ever had a positive TST, they are required to submit the following documentation as part of their Communicable Disease Screening Form. <b>Note: Both documents 1 &amp; 2 are required:</b></p> <ol style="list-style-type: none"> <li>1) Copy of recent chest x-ray report (x-ray must be less than 1 year old).</li> </ol> <p style="text-align: center;"><b>AND</b></p> <ol style="list-style-type: none"> <li>2) Annual TB Surveillance letter. A copy of this letter can be found on the clearance website.</li> </ol> <p>Future TSTs are <u>not</u> required but the annual TB Surveillance letter must be completed and submitted on an <b>annual</b> basis as part of your renewal clearance package.</p> <p><b>Note:</b> if indicated as moderate or high risk for active TB, a new chest x-ray will be required.</p>	<p><b>Baseline Assessment</b> <b><u>Two Step (TST) Documentation Required</u></b></p> <p><b>Step 1 Date Given:</b> (dd/mm/yy) _____</p> <p><b>Step 1 Date Read:</b> (dd/mm/yy) _____</p> <p style="text-align: right;"><b>Result/Induration:</b> _____ mm</p> <p style="text-align: right;"><b>Interpretation +/-:</b> _____</p> <p><b>Signature &amp; Designation:</b> _____</p> <p><b>Step 2 Date Given:</b> (dd/mm/yy) _____</p> <p><b>Step 2 Date Read:</b> (dd/mm/yy) _____</p> <p style="text-align: right;"><b>Result/Induration:</b> _____ mm</p> <p style="text-align: right;"><b>Interpretation +/-:</b> _____</p> <p><b>Signature &amp; Designation:</b> _____</p> <p><b><u>One Step Tuberculin Skin Test (TST)</u></b></p> <p><b>Date Given:</b> (dd/mm/yy) _____</p> <p><b>Date Read:</b> (dd/mm/yy) _____</p> <p style="text-align: right;"><b>Result/Induration:</b> _____ mm</p> <p style="text-align: right;"><b>Interpretation +/-:</b> _____</p> <p><b>Signature &amp; Designation:</b> _____</p> <p><b><u>Positive Result</u></b></p> <p><input type="checkbox"/> Student has a history of a positive TST. Date of positive TST: _____</p> <p style="background-color: yellow;"><b>**Must include chest x-ray and TB surveillance letter</b></p>

**TETANUS/DIPHTHERIA**

<b>Student Name:</b> _____		<b>Student Number:</b> _____	
<b>Instructions</b>		<b>Immunization/Serologic Status</b>	
<p>Students must document vaccination for Tetanus &amp; Diphtheria annually and be vaccinated every 10 years. To meet clearance requirements, immunity cannot expire before September 1 of the following clearance cycle.</p> <p>It is the <u>responsibility of the student</u> to ensure that these boosters remain up to date after admittance into the RPN to BScN Blended Program.</p>		<p><b>Primary vaccine or date of most recent booster received within the last 10 years:</b></p> <p>Vaccine Name: _____</p> <p>Date (dd/mm/yy) _____</p>	
<p><b><u>Licensed Healthcare Provider Declaration:</u></b>          I confirm that the information provided on this form is correct:</p> <p>Name (please print): _____ Date: _____</p> <p>Signature: _____ Designation: _____</p>			

<b>Student Name:</b> _____	<b>Student Number:</b> _____
<b>Instructions</b>	<b>Immunization/Serologic Status</b>
<b>FLU</b>	
<p>The flu shot is <b>optional</b>. Students who do not get the annual flu shot will be subject to agency policy, and it may impact your ability to complete clinical.</p> <p>If you have received the flu shot, you are encouraged to submit proof as part of your CDSF.</p>	<p><b>Documentation of Vaccination:</b></p> <p>Dose #1    Date (dd/mm/yy) _____</p> <p><b>Please check one of the following:</b></p> <p><input type="checkbox"/> <b>Yes</b> - Flu proof is attached</p> <p><input type="checkbox"/> <b>No</b> - Flu proof is not attached</p>
<p><b><u>Licensed Healthcare Provider Declaration:</u></b>          I confirm that the information provided on this form is correct:</p> <p>Name (please print): _____ Date: _____</p> <p>Signature: _____ Designation: _____</p>	