

RPN to BScN Blended Learning Program Communicable Disease Screening Form Renewal

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 RPN to BScN Blending Learning Program includes clinical placements as an essential component of the program. In order to protect yourself and the client you will be interacting with, you must complete all required immunizations upon admission and annually as indicated. You WILL 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.

- Failure to submit a signed and duly completed Communicable Disease Screening Form to the Nipissing University School of Nursing will result in ineligibility to register for clinical courses. Please ensure that your licensed healthcare provider (HCP) understands that every page and section MUST be completed in full and that a signature from a licensed healthcare provider is also required on each page. Incomplete documents will be rejected.
- The following requirements may differ from your workplace, but these are the requirements that are necessary for the School of Nursing at Nipissing University.
- Students can transcribe the information into each section then have it verified and signed by a licensed HCP OR students can have the form completed and signed by a licensed HCP (Physician, Nurse Practitioner, Registered Nurse or Registered Practical Nurse). The designation of the healthcare provider must also be included.
- The CNO professional misconduct provides direction regarding conflict of interest. Please do not have close friends or family members sign your documents as your licensed HCP.
- Electronic signatures by Healthcare Providers are not accepted. Please print documents, have them signed, and scan them saved in PDF format.
- Agencies may have additional requirements that are separate from the School of Nursing and additional items may need to be completed if requested. Agencies may refuse access to students who do not meet their requirements.

The completed Communicable Disease Screening form is to be scanned and uploaded as a single PDF file to the Nursing Clearance Website. Please note that you must submit all documents as per the guidelines in order for your package to be reviewed. Emails, faxes or mailed hard copies will NOT be accepted. Questions regarding these instructions, the form and/or the requirements, should be directed to the Clinical Clearance at clinicalclearance@nipissingu.ca or 705-474-3450 Ext. 4579.

Kind Regards,

Clinical Clearance Team

Student Name: _____	Student Number: _____
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Instructions	Immunization/Serologic Status
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**TUBERCULOSIS
Tuberculin Skin Test (TST)**

<p>A current one-step TST dated no earlier than September 1 of the clearance period is required.</p> <p>Positive Results: If students have ever had a positive TST, they are required to submit the Annual TB Surveillance letter. Please see Appendix A of this document.</p> <p>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.</p> <p>Note: if indicated as moderate or high risk for active TB, a new chest x-ray will be required.</p>	<p><u>One Step Tuberculin Skin Test (TST)</u></p> <p>Date Given: (dd/mm/yy) _____</p> <p>Date Read: (dd/mm/yy) _____</p> <p style="padding-left: 40px;">Result/Induration: _____ mm</p> <p style="padding-left: 40px;">Interpretation +/-: _____</p> <p>Signature & Designation: _____</p> <p><u>Positive Result</u></p> <p><input type="checkbox"/> Student has a history of a positive TST. Date of positive TST: _____</p> <p>**Must include TB surveillance letter please see Appendix A</p> <p>**New chest x-ray only if indicated as moderate or high risk.</p>
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Licensed Healthcare Provider Declaration:
 I confirm that the information provided on this form is correct:

Name (please print): _____ Date: _____

Signature: _____ Designation: _____

TETANUS/DIPHTHERIA	
Student Name: _____	Student Number: _____
Instructions	Immunization/Serologic Status
<p>Students must document vaccination for Tetanus & 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>Primary vaccine or date of most recent booster received within the last 10 years:</p> <p>Vaccine Name: _____</p> <p>Date (dd/mm/yy) _____</p>
<p><u>Licensed Healthcare Provider Declaration:</u> I confirm that the information provided on this form is correct:</p> <p>Name (please print): _____ Date: _____</p> <p>Signature: _____ Designation: _____</p>	

Student Name: _____	Student Number: _____
Instructions	Immunization/Serologic Status
FLU	
<p>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.</p> <p>If you have received the flu shot, you are encouraged to submit proof as part of your CDSF.</p> <p style="text-align: center;"> <input type="checkbox"/> Yes - Flu proof is attached <input type="checkbox"/> No - Flu proof is not attached </p>	<p>Please check one of the following:</p> <p> <input type="checkbox"/> Yes - Proof of FLU vaccine below <input type="checkbox"/> Yes - I intend to receive my FLU vaccination at a later date <input type="checkbox"/> No - I do not intend to receive the FLU vaccination </p> <p>Documentation of Vaccination:</p> <p>Dose #1 Date (dd/mm/yy) _____</p> <p>Please check one of the following:</p>
<p><u>Licensed Healthcare Provider Declaration:</u> I confirm that the information provided on this form is correct:</p> <p>Name (please print): _____ Date: _____</p> <p>Signature: _____ Designation: _____</p>	

Appendix A - Tuberculosis (TB) Surveillance Letter*

Student Name: _____ Student Number: _____

As the student's primary health care provider, I _____
Please Print Name

have deemed this student, whose Tuberculosis skin test is 'positive' (10mm or greater) to be absent of TB symptoms and at a (please check off appropriate box):

low risk for active TB.

moderate or high risk for active TB.

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

(Symptoms may include coughing that lasts longer than 2 weeks with green, yellow, or bloody sputum; weight loss, fatigue, fever, night sweats, chills, chest pain, shortness of breath and loss of appetite.)

Chest x-ray results required as per instructions from the Communicable Disease Screening Form (must attach copy of results if not previously submitted):

Result

Date

Physician/Nurse Practitioner Signature & Designation

Date

*Required for students with a current or past positive TB skin test result