

RPN to BScN Blended Learning 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, true and may be shared as required with Nipissing University, Clinical Faculty, Administrative/Support Staff, and Placement Agencies.

Signature: _____

Date: _____

The RPN to BScN Blending Learning Program includes clinical placements as an essential component of the program. To protect yourself and the client you will be interacting with, you must complete all required immunizations upon admission and annually as indicated. These requirements may differ from what is required at your workplace but are mandatory to participate in clinical practicum while enrolled in our program. 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 you comply with all requirements.

1. 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, including name and student ID on each page. A signature from a licensed healthcare provider is also required on each page. Incomplete documents will be rejected.
2. Students can transcribe the information into each section but **must have each page verified and signed by a licensed healthcare provider (HCP) (Physician, Nurse Practitioner, Registered Nurse, or Registered Practical Nurse) OR** students can have the form completed and signed by a licensed HCP in full. The designation of the healthcare provider must also be included. Any changes to the data included on each page must include a new HCP declaration.
3. The CNO professional misconduct provides direction regarding conflict of interest. **Do not have close friends or family members sign your documents as your licensed HCP.**
4. Electronic signatures by Healthcare Providers are **not** accepted. Please print documents, complete each page in full, have pages signed, scanned, and saved in PDF format to upload to the clearance website.
5. 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, multiple page PDF file to the Nursing Clearance Website. Please note that you must submit all documents as per the guidelines 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 Clearance Team at clinicalclearance@nipissingu.ca or 705-474-3450 Ext. 4579.

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| Student Name: _____ | Student Number: _____ |
| TUBERCULOSIS Tuberculin Skin Test (TST) | |
| Instructions | Immunization/Serologic Status |
| <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 September 1 of the clearance period.</p> <p style="text-align: center;">OR</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>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.</p> <p>Note: Both documents 1 & 2 are required: Copy of recent chest x-ray report (x-ray less than 1 year old).</p> <p style="text-align: center;">AND</p> <p>1) Annual TB Surveillance letter completed by your primary healthcare provider (Nurse Practitioner or Physician). Please see Appendix A.</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>Baseline Assessment <u>Two Step (TST) Documentation Required</u></p> <p>Step 1 Date Given: (dd/mm/yyyy) _____</p> <p>Step 1 Date Read: (dd/mm/yyyy) _____</p> <p>Result/Induration: _____mm</p> <p>Interpretation +/-: _____</p> <p>Step 2 Date Given: (dd/mm/yyyy) _____</p> <p>Step 2 Date Read: (dd/mm/yyyy) _____</p> <p>Result/Induration: _____mm</p> <p>Interpretation +/-: _____</p> <p><u>One Step Tuberculin Skin Test (TST)</u></p> <p>Date Given: (dd/mm/yyyy) _____</p> <p>Date Read: (dd/mm/yyyy) _____</p> <p>Result/Induration: _____mm</p> <p>Interpretation +/-: _____</p> <p>Positive Result</p> <p><input type="checkbox"/> Student has a history of a positive TST. Date of positive TST: _____</p> <p style="background-color: yellow;">**Must include chest x-ray and TB surveillance letter (Appendix A)</p> |
| Licensed Healthcare Provider Declaration: | |
| I confirm that the information provided on this form is correct: | |
| Name (print): _____ | Date: _____ |
| Signature: _____ | Designation: _____ |

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

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| Student Name: | Student Number: |
| TETANUS/DIPHThERIA | |
| 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 responsibility of the student 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/yyyy) _____</p> |
| <p>Licensed Healthcare Provider Declaration: I confirm that the information provided on this form is correct:</p> <p>Name (please print): _____ Date: _____</p> <p>Signature: _____ Designation: _____</p> | |

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| Student Name: | Student Number: |
| MEASLES, MUMPS, RUBELLA (MMR) | |
| Instructions | Immunization/Serologic Status |
| <p>Students must document immunity via one of the following:</p> <p>Documentation of vaccination with 2 doses (regardless of year of birth)</p> <p style="text-align: center;">OR</p> <p>Documented laboratory evidence of immunity (serologic testing/bloodwork for Measles, Mumps and Rubella).</p> <p>Note: if titre results are non-reactive/non-immune/indeterminate, then documentation of full vaccination is required by the School of Nursing.</p> | <p>MMR Vaccination</p> <p>Dose #1 Date (dd/mm/yyyy) _____</p> <p>Dose #2 Date (dd/mm/yyyy) _____</p> <p style="text-align: center;">OR</p> <p>Titre Results **Antibody Titre must not be taken sooner than 1 month following completion of vaccination series**</p> <p>Measles Date of Titre: (dd/mm/yyyy) _____ <input type="checkbox"/> Reactive/Immune (+) <input type="checkbox"/> Non-Reactive/Non-Immune (-) <input type="checkbox"/> Indeterminate</p> <p>Mumps Date of Titre: (dd/mm/yyyy) _____ <input type="checkbox"/> Reactive/Immune (+) <input type="checkbox"/> Non-Reactive/Non-Immune (-) <input type="checkbox"/> Indeterminate</p> <p>Rubella Date of Titre: (dd/mm/yyyy) _____ <input type="checkbox"/> Reactive/Immune (+) <input type="checkbox"/> Non-Reactive/Non-Immune (-) <input type="checkbox"/> Indeterminate</p> <p>Note: If a booster has also been given</p> <p>Booster Date: (dd/mm/yyyy) _____</p> |
| <p>Licensed Healthcare Provider Declaration: I confirm that the information provided on this form is correct:</p> <p>Name (please print): _____ Date: _____</p> <p>Signature: _____ Designation: _____</p> | |

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| Student Name: | Student Number: |
| POLIO | |
| Instructions | Immunization/Serologic Status |
| <p>Students must document immunity via one of the following:</p> <p>1) Document full child series Polio vaccination.</p> <p>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)</p> <p style="text-align: center;">OR</p> <p>2) Document full adult series Polio vaccination.</p> <p>Students who are unable to provide proof of immunization are required to complete a full adult series vaccination.</p> <p style="text-align: center;">OR</p> <p>3) Polio Vaccination Attestation letter. Please see Appendix B.</p> <p>If you do not have proof of polio vaccination or are unsure of immunization status, then the Polio Vaccination Attestation letter must be completed by your Primary Healthcare provider (a Physician or Nurse Practitioner). The Polio Vaccination Attestation letter can be found on the clearance website and must be submitted with your CDSF.</p> | <p>1) Primary Series Vaccination (Child)</p> <p>Dose #1 Date (dd/mm/yyyy) _____</p> <p>Dose #2 Date (dd/mm/yyyy) _____</p> <p>Dose #3 Date (dd/mm/yyyy) _____</p> <p>Dose #4 Date (dd/mm/yyyy) _____</p> <p>Dose #5 Date (dd/mm/yyyy) * _____</p> <p>*Verify if 5th dose was not required _____ (initial)</p> <p style="text-align: center;">OR</p> <p>2) Primary Series Vaccination (Adult)</p> <p>Dose #1 Date (dd/mm/yyyy) _____</p> <p>Dose #2 Date (dd/mm/yyyy) _____</p> <p>Dose #3 Date (dd/mm/yyyy) _____</p> <p style="text-align: center;">OR</p> <p>3) <input type="checkbox"/> Polio Vaccination Attestation letter</p> <p>Completed by primary healthcare provider. The Polio Vaccination Attestation letter - Appendix B must be included with your CDSF submission.</p> |
| <p>Licensed Healthcare Provider Declaration:</p> <p>I confirm that the information provided on this form is correct:</p> <p>Name (please print): _____ Date: _____</p> <p>Signature: _____ Designation: _____</p> | |

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| Student Name: | Student Number: |
| HEPATITIS B | |
| Instructions | Immunization/Serologic Status |
| <p>Students must provide both dates of primary series final dose and documented immunity.</p> <p>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.</p> <p>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.</p> <p>***Note: To be considered 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. ***</p> | <p>Dates of vaccination:</p> <p>Dose #1 Date (dd/mm/yyyy): _____</p> <p>Dose #2 Date (dd/mm/yyyy): _____</p> <p>Dose #3 Date (dd/mm/yyyy): _____</p> <p>Surface Antibody Level (Anti-HBs Titre)</p> <p>Date of Titre: (dd/mm/yyyy): _____</p> <p>**Antibody Titre must not be taken sooner than 1 month following completion of vaccination series**</p> <p><input type="checkbox"/> Reactive/Immune (+)</p> <p><input type="checkbox"/> Non-Reactive/Non-Immune (-)</p> <p>If non-reactive, student must complete full repeat series (3 doses recommended for HCPs):</p> <p>Dose #1 Date (dd/mm/yyyy): _____</p> <p>Dose #2 Date (dd/mm/yyyy): _____</p> <p>Dose #3 Date (dd/mm/yyyy): _____</p> <p>*Verify if 3rd dose was not required _____ (initial)</p> <p>Repeat Surface Antibody Level (Anti-HBs Titre)</p> <p>**Antibody Titre must not be taken sooner than 1 month following completion of vaccination series**</p> <p>Date of Titre: (dd/mm/yyyy): _____</p> <p><input type="checkbox"/> Reactive/Immune (+)</p> <p><input type="checkbox"/> Non-Reactive/Non-Immune (-)</p> |
| <p>Licensed Healthcare Provider Declaration:</p> <p>I confirm that the information provided on this form is correct:</p> <p>Name (please print): _____ Date: _____</p> <p>Signature: _____ Designation: _____</p> | |

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| Student Name: | Student Number: |
| FLU | |
| Instructions | Immunization/Serologic Status |
| <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>Please check one of the following:</p> <p><input type="checkbox"/> Yes - Proof of FLU vaccine. below</p> <p><input type="checkbox"/> Yes - I intend to receive FLU vaccination later.</p> <p><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/yyyy) _____</p> |
| <p>Licensed Healthcare Provider Declaration: 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

This form is for students with a history of positive TB skin test result. This form must be completed by your primary healthcare provider (Nurse Practitioner or Physician).

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

**Primary health care provider required*



Appendix B - Polio Vaccination Attestation

Student Name: _____ Student Number: _____

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

Attest that this student has received a full Polio Vaccination Series, but records are not available and (choose one from the list below).

- No further vaccinations are required.
- Booster given on _____(dd/mm/yyyy), no further vaccinations required.
- Patient will begin full adult series, first dose given on _____(dd/mm/yyyy)

* Physician/Nurse Practitioner Signature & Designation

Date

**Primary health care provider required*