Collaborative and RPN Bridging BScN Learning Program
Communicable Disease Screening Renewal 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 Collaborative and RPN Bridging BScN Programs include clinical placements as an essential component of the program. To protect yourself and the client you may 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 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 Clearance Office 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. **Do not have close friends or family members sign your documents as your licensed HCP**. Doing so is considered a conflict of interest and if discovered, documentation will be rejected.
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. Placement 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.

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

TUBERCULOSIS
Tuberculin Skin Test (TST)

Instructions	**Immunization/Serologic Status**
A current one-step TST dated no earlier than January 1 for Fast Tracking Spring/Summer students or March1 for Fall returning students. **Positive Results:** First instance of positive results will require a chest x-ray less than 1 year old as well as TB Surveillance Letter. Please see Appendix A of this document. 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 a change in risk from low to moderate or high risk for active TB, a new chest x-ray will be required to rule out active TB.	**One Step Tuberculin Skin Test (TST)** **Date Given:** (dd/mm/yyyy) _____ **Date Read:** (dd/mm/yyyy) _____ **Result/Induration:** _____mm **Interpretation +/-:** _____ **Positive Result** ☐ Student has a history of a positive TST. Date of positive TST: _____ **Must include TB surveillance letter please see Appendix A

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

Name (please print): _____ Date: _____

Signature: _____ Designation: _____

Student Name: _____	**Student Number:** _____
TETANUS/DIPHTHERIA	
Instructions	**Immunization/Serologic Status**
Students must document most recent vaccination for Tetanus & Diphtheria annually and be vaccinated every 10 years. It is the responsibility of the student to ensure that these boosters remain up to date after admittance into the Collaborative or RPN to BScN Program.	**Primary vaccine or date of most recent booster received within the last 10 years:** Vaccine Name: _____ Date (dd/mm/yyyy) _____

Licensed Healthcare Provider Declaration:

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

Name (please print): _____ Date: _____

Signature: _____ Designation: _____

Appendix A - Tuberculosis (TB) Surveillance Letter*

Student Name: _____ Student Number: _____

As the student's primary health care provider, I _____ 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 <u>new</u> 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.**