RPN to BScN Blended Learning Program

Communicable Disease Screening Form - Initial

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:** _____

**Per the Electronic Commerce Act of Ontario, an electronic signature has the same legal effect as a handwritten signature. Accordingly electronic signatures on these documents confirm agreement with the information provided within.*

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 is 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. 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 Office at clinicalclearance@nipissingu.ca or 705-474-3450 Ext. 4579.

NIPISSING UNIVERSITY

Student Name:	Student Number:

TUBERCULOSIS
Tuberculin Skin Test (TST)

Instructions

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.

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 less than 1 year old).
AND
2) Annual TB Surveillance letter completed by your primary healthcare provider (Nurse Practitioner or Physician). Please see Appendix A.

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. Repeat chest x-rays will only be required if your HCP provider deems it necessary OR if your TB Surveillance Letter indicates a moderate OR high risk for active TB.

Immunization/Serologic Status

Baseline Assessment
Two Step (TST) Documentation Required

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

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

Result/Induration:_____mm

Interpretation +/-: _____

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

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

Result/Induration:_____mm

Interpretation +/-: _____

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 chest x-ray and TB surveillance letter (Appendix A)

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

Name (print):_____ Date:_____

Signature:_____ Designation: _____

(Note: This form to be signed & dated, after One Step Tuberculin Skin Test (TST) date read)

Student Name:	Student Number:
VARICELLA	
Instructions	**Immunization/Serologic Status**
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 (serologic testing/bloodwork for Varicella) **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/yyyy) _____ Dose #2 Date (dd/mm/yyyy) _____ **OR** **Date of Titre: (dd/mm/yyyy)** _____ **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/yyyy) _____
Licensed Healthcare Provider Declaration: I confirm that the information provided on this form is correct: Name (print):_____ Date:_____ Signature:_____ Designation: _____	

Student Name:	Student Number:
TETANUS/DIPHTHERIA	
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 September 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 RPN to BScN Blended 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: _____

Student Name:	Student Number:
MEASLES, MUMPS, RUBELLA (MMR)	
Instructions	**Immunization/Serologic Status**
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/yyyy) _____ Dose #2 Date (dd/mm/yyyy) _____ **OR** **Titre Results** **Antibody Titre must not be taken sooner than 1 month following completion of vaccination series**** **Measles** Date of Titre: (dd/mm/yyyy) _____ ☐ Reactive/Immune (+) ☐ Non-Reactive/Non-Immune (-) ☐ Indeterminate **Mumps** Date of Titre: (dd/mm/yyyy) _____ ☐ Reactive/Immune (+) ☐ Non-Reactive/Non-Immune (-) ☐ Indeterminate **Rubella** Date of Titre: (dd/mm/yyyy) _____ ☐ Reactive/Immune (+) ☐ Non-Reactive/Non-Immune (-) ☐ Indeterminate **Note: If a booster has also been given** Booster 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: _____	

Student Name:	**Student Number:**
POLIO	
Instructions	**Immunization/Serologic Status**
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) Polio Vaccination Attestation letter. Please see Appendix B. *Note: 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.	1) Primary Series Vaccination (Child) **Dose #1 Date** (dd/mm/yyyy) _____ **Dose #2 Date** (dd/mm/yyyy) _____ **Dose #3 Date** (dd/mm/yyyy) _____ **Dose #4 Date** (dd/mm/yyyy) _____ **Dose #5 Date** (dd/mm/yyyy) * _____ *Verify if 5th dose was not required_____(initial) **OR** 2) Primary Series Vaccination (Adult) **Dose #1 Date** (dd/mm/yyyy) _____ **Dose #2 Date** (dd/mm/yyyy) _____ **Dose #3 Date** (dd/mm/yyyy) _____ **OR** 3) □ Polio Vaccination Attestation letter Completed by primary healthcare provider. The Polio Vaccination Attestation letter - Appendix B must be included with your CDSF submission.

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:

HEPATITIS B

Instructions	Immunization/Serologic Status
Students must provide both of the following: (1) documentation showing completion of the full Hepatitis B vaccination series (including the final dose), and (2) proof of immunity through a Hepatitis B titre. Please note that <u>both</u> are required to meet clearance requirements. 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". <u>A third series of HB vaccinations will not be required.</u> Non- responders will be required to receive post-exposure prophylaxis HB immunization after any potential exposure to HB. ******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. ******	**Dates of vaccination:** Dose #1 Date (dd/mm/yyyy): _____ Dose #2 Date (dd/mm/yyyy): _____ Dose #3 Date (dd/mm/yyyy): _____ **Surface Antibody Level (Anti-HBs Titre)** **Date of Titre:** (dd/mm/yyyy): _____ **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/yyyy): _____ Dose #2 Date (dd/mm/yyyy): _____ Dose #3 Date (dd/mm/yyyy): _____ *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/yyyy): _____ ☐ Reactive/Immune (+) ☐ Non-Reactive/Non-Immune (-)

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

Name (please print):_____ Date:_____

Signature:_____ Designation: _____

Student Name:	**Student Number:**
FLU	
Instructions	**Immunization/Serologic Status**
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.	Please check one of the following: ☐ **Yes** - Proof of FLU vaccine. below ☐ **Yes** - I intend to receive FLU vaccination later. ☐ **No** - I do not intend to receive the FLU vaccination. **Documentation of Vaccination:** Dose #1 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

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*