CAMPUS HEALTH SERVICES
IMMUNIZATION RECORD FORM FOR ALL STUDENTS WHO REQUIRE VACCINES FOR PLACEMENT

***Please complete ALL information requested on THIS PAGE ONLY and bring completed form to your Campus Health Centre along with your immunization record and health card**

The information you provide is **confidential.** It is intended for use by Sheridan's Health Centre staff only to ensure that you meet Immunization requirements for your clinical placements. This information **will not** be released to anyone outside the Health Centre without your written permission. These **COMPULSORY** requirements are based on recommendations established by the Ontario Hospitals Act, Days Nursery Act, Canadian Immunization Standards, Health Canada and both the Halton and Peel Medical Officers of Health.

Health Number ___ ___ ___ ___- ___ ___ ___- ___ ___ ___ **Version Code** ___ ___ **(letters)**

Expiry Date_____ **(year)** _____ **(month)** _____ **(day)**

_____ _____

Your Name (exactly as printed on your Health Card) **If out of Province, Address & Postal Code**

☐ **DAVIS CAMPUS** ☐ **TRAFALGAR CAMPUS**

Name: _____ _____ _____

Last **First (Legal)** **Preferred (if applicable)**

Gender: ☐M ☐F **Preferred Gender Identity:** _____ **Date of Birth:** _____ **(yr)** _____**(mth)**_____**(day)** **Age:** _____

Program: _____ **Currently in Year (please circle): 1 2 3 4 5**

Program Length: _____ **(# of years) Student Number** _____ **Email Address** _____

Home Phone Number: (**)** _____ **and/or Cell Number (** **)** _____

Address (During College Year): _____ **City** _____ **Postal Code**_____

Notify in Emergency _____**Relationship** _____ **Phone (** **)** _____

Family Physician _____ **City**_____ **Phone (** **)** _____

ALLERGIES ☐ **Yes** ☐ **No** **If yes, please list and indicate which (if any) are life threatening and require an Epi-pen.**

_____

PLEASE NOTE

THERE IS A $20.00 FEE TO RETRIEVE AND COPY THIS FORM AT A LATER DATE.

Once completed, a copy will be given to you free of charge. KEEP THE COPY FOR YOUR OWN RECORDS.

The statements given on this form are true to the best of my knowledge and belief. I understand that misstatement is grounds for cancellation of admission to the clinical component of the program. I understand that the College has the right to cancel my admission privilege on the basis of medical information submitted or withheld. I understand that it is my responsibility to inform the appropriate Sheridan Personnel of any Communicable Disease, Special Need or Medical Condition which may place me at risk or pose a risk to others at Sheridan or on placement.

Copy Received (Student's Signature) : _____

NOTE-*ALL INFORMATION TO BE COMPLETED BY A SHERIDAN HEALTH CENTRE NURSE

Students **WILL NOT BE ALLOWED** on placement until **ALL** immunization information is complete and clearance is issued by the **HEALTH CENTRE**.

1. Td/Tdap(Tetanus,Diptheria,Pertussis) primary series: Yes ☐ **Date of Td / Tdap: _____*proof required**
(Tetanus booster required every 10 years)

If you have no proof of primary series, 3 doses of vaccine are required.
Date: #1_____(Tdap / Td) #2 _____ (Tdap / Td) #3_____ (Tdap / Td)
(4-8 wks after 1st) (6-12mths after 2nd)

2. MMR (Measles, Mumps, Rubella vaccine) (A) OR (B) * CHOOSE ONE ONLY

(A) Proof of two doses of Measles, Mumps, Rubella (MMR) vaccine
#1 MMR Vaccine Date:_____ #2 MMR Vaccine Date:_____ (4-8 wks after 1st) *proof required

OR

(B) Proof of immunity to Measles, Mumps and Rubella (blood test - only if born prior to 1970). **Results may take up to 6 weeks**

Date: _____ Result - Immune to: ☐ MEASLES ☐ MUMPS ☐ RUBELLA *copy of results
IF NOT IMMUNE TO ALL, you will require an MMR vaccine. A booster MMR may also be recommended if you have no proof of previous immunization.

MMR VACCINE Date: _____ BOOSTER MMR VACCINE Date: _____ *proof required

3. TUBERCULIN TESTING : A 2-Step Tuberculin (TB) Skin Test is required ONCE in a lifetime to establish a baseline for all future testing.

#1 Date: _____ Result (read 48-72 hours after test done) Date Read: _____ mm induration : _____

#2 Date:_____ Result (read 48-72 hours after test done) Date Read:_____ mm induration: _____
(given 1-4 weeks after #1)
***proof required**

If Positive (10 mm or more induration), a chest x-ray is required within the last 12 months.
Date: _____ Result: _____ *copy of report
If you have had a documented 2-step TB test more than 1 year ago, only a 1-step TB Test is needed.

Date:_____ Result (read 48-72 hours after test is done) Date Read: _____ mm induration: _____
***proof required**

If Positive (10 mm or more induration), a chest x-ray is required within the last 12 months.
Date: _____ Result: _____ *copy of report

If you have had a documented 2-step TB test more than 1 year ago, only a 1-step TB Test is needed.

Date:_____ Result (read 48-72 hours after test is done) Date Read: _____ mm induration: _____
***proof required**

If Positive (10 mm or more induration), a chest x-ray is required within the last 12 months.
Date: _____ Result: _____ *copy of report

4. HEPATITIS B -(COMPULSORY for PN & Pharmacy Programs. HIGHLY recommended for ECE, ECL & PSW program)
Hepatitis B / Hepatitis A&B (please circle)

#1. Date: _____ #2. Date: _____ and/or #3. Date: _____ *proof required
(min. 1 month after 1st) (min. 5 months after 2nd)

Post vaccine titre (draw 1 month after last vaccine) Date: _____Result: ☐ Immune _____ ☐ Non-Immune *copy of result

IF NOT IMMUNE, you will be required to repeat the primary series or receive a booster. This is determined on an individual basis depending on your immunization history.

Hepatitis B / Hepatitis A&B (please circle)
#1. Date: _____ #2. Date: _____ and/or #3. Date: _____ *proof required

Post vaccine titre (draw 1 month after last vaccine) Date: _____Result: ☐ Immune _____ ☐ Non-Immune *copy of result
If still not immune after the second series is completed, you are considered a vaccine non-responder.

5. VARICELLA - (COMPULSORY for PN & Pharmacy Programs. HIGHLY recommended for ECE, ECL & PSW program)

Date: _____ Result- ☐ Immune ☐ Non-Immune *copy of result

IF NOT IMMUNE, you will require the Varicella vaccine #1 Date: _____ #2 Date:_____ *proof required
(4-8 wks after 1st, per monograph)

6. INFLUENZA – (Compulsory for all PN, PSW & Pharmacy Programs) Date: _____ *proof required*
Date: _____ *proof required*

Revised April 2013