ALGONQUIN COLLEGE
Health Services

IMMUNIZATION FORM 2013-2014

PLEASE PRINT CLEARLY

PERSONAL INFORMATION DATA ALL FIELDS MUST BE COMPLETE IN ORDER TO PROCESS THIS FORM

NAME: _____ Date of Birth: _____/_____/_____ Sex: ☐ M / ☐ F
Family name *given name* *D / M / Y*

Address: _____
Street *City* *Province* *Postal code*

E-mail Address: _____

Health Card Information: Province: _____ Health Card # _____ Expiry Date: _____

Other Health Insurance _____ Telephone #: Home: _____ Cell: _____
(Private- Company name / Policy #)

Program Name: _____ Program start date: _____/_____ ☐ Full time ☐ Part time ☐ On-line
Month / Year

Please list any ALLERGIES:

CONSENT:

The information on these forms is kept confidential within the Health Services Office. However, if your records are not complete, this will be communicated to the College staff responsible for your placement.

I confirm that I have read the above statement and I give consent to release information as is necessary for my clinical / placement.

Signature of Student _____ *Date* _____

1. IMMUNIZATION RECORDS: PLEASE SUBMIT COPIES OF YOUR VACCINATION RECORDS

☐ COPY OF IMMUNIZATION RECORD ENCLOSED ☐ RECORDS NOT AVAILABLE If records are not available, please consult Health Services

2. TETANUS, DIPTHERIA , POLIO and PERTUSSIS VACCINES:

Documented proof of a primary series is required, OR an adult primary series is required. A single dose of Pertusis is required for all adults.

A. Do you have documented proof of a completed primary series? ☐ YES ☐ COPY OF RECORD ATTACHED (MANDATORY)
or ☐ NO If no, the primary series will need to be completed (MANDATORY)
or if no records of any vaccines, an adult primary series is required (see below)

B. Date of last Tetanus vaccine _____ Type of vaccine given _____ ☐ COPY OF RECORD ATTACHED (MANDATORY)

C. Date of adult dose of Adacel or Boostrix (given at ≥ age 14) _____ ☐ COPY OF RECORD ATTACHED (MANDATORY)

ADULT PRIMARY SERIES
1st dose (Adacel or Boostrix and IPV) Date: _____ by _____ RN / MD
2nd dose (TdPolio -2 months after 1st visit) Date: _____ by _____ RN / MD
3rd dose (TdPolio - 6-12 months after 2nd visit) Date: _____ by _____ RN / MD

3. VARICELLA (CHICKEN POX) IMMUNITY: PLEASE ENSURE TB TESTING IS COMPLETE PRIOR TO GIVING A VARICELLA VACCINE.

Date of childhood vaccine for Varicella (if given) _____ ☐ COPY OF RECORD ATTACHED (MANDATORY if vaccine given)

A blood test result for Varicella Antibodies is required:

Date drawn: _____ Result ☐ IMMUNE ☐ NON-REACTIVE ☐ COPY OF LAB ATTACHED (MANDATORY)

IF YOU ARE NOT IMMUNE, vaccination is required. If you were given a single dose of the chicken pox vaccine in childhood, a single booster dose is required. If you have never been vaccinated for chicken pox and are not immune, 2 doses are mandatory.

Dose #1 Date: _____ Vaccine type _____ Lot # _____ by _____ RN/MD

Dose #2 * Date: _____ Vaccine type _____ Lot # _____ by _____ RN/MD
(4 - 8 weeks after 1st dose)

NAME:_____ DATE OF BIRTH _____/_____/_____
family name given name day / month / year

4. MMR

NOTE TO HEALTH CARE PROVIDERS: PLEASE ENSURE TB TESTING IS COMPLETE PRIOR TO GIVING AN MMR VACCINE.

Documentation of two MMR is required: For students who received a second measles only vaccine, a second MMR is required. If no records are available, blood work demonstrating immunity to Measles, Mumps and Rubella is required.

Date of 1st MMR: _____ and Date of 2nd MMR: _____ ❑ COPY OF RECORD ATTACHED (MANDATORY)

OR Submit a copy of blood test results for Measles, Mumps and Rubella Antibodies: ❑ COPY OF LAB ATTACHED (MANDATORY)

Date drawn: _____ Results: Measles ❑ Reactive ❑ Non- Reactive or Indeterminate

Mumps ❑ Reactive ❑ Non- Reactive or Indeterminate

Rubella ❑ Reactive ❑ Non- Reactive or Indeterminate

IF YOU ARE NOT IMMUNE: A booster dose is required: Date given: _____ by _____ RN/MD

5. TB TESTING

NOTE: TB testing must be completed prior to any live vaccines such as MMR or Varicella boosters.

A 2 - STEP TUBERCULIN SKIN TEST is required REGARDLESS OF BCG HISTORY. The TB tests should be given 1 – 3 weeks apart. TB testing must be within 3 months of the start date of your program. A TB test is invalid if it is given in the 30 day period following the administration of any live vaccines.

PREVIOUS POSITIVE TB TEST: If you have a documented history of a previous positive TB test (induration measuring equal to or greater than 10 mm), a TB skin test is NOT REQUIRED. Proceed instead to Chest X-ray

STEP ONE:

Date: _____ L R Forearm Date read: _____ Result _____mm TB test is positive (≥10 mm) proceed to chest X-ray

Lot: _____ Signature:_____RN/MD TB test is negative (<10mm) repeat TB test in 1– 3 weeks

STEP TWO:

Date: _____ L R Forearm Date read: _____ Result _____mm TB test is positive (≥10 mm) proceed to chest X-ray

Lot: _____ Signature:_____ RN/MD TB test is negative (<10mm) repeat TB annually

CHEST X-RAY: Required ONLY if TB reaction is equal to or greater than 10 mm.

ATTACH A COPY OF A RECENT X-RAY REPORT (i.e.: within 6 months of your program start date) ❑ COPY OF REPORT ATTACHED (MANDATORY)

Date of X-ray: _____ Result: _____ INH treatment prescribed? YES NO If INH was not prescribed, please state reason why

_____

6. HEPATITIS B VACCINES / IMMUNITY

HEPATITIS B VACCINE is MANDATORY. If you have not already been vaccinated for Hepatitis B, you may elect to receive the vaccine at Algonquin College Health Services for $30 per injection. You may have had either a 2 dose series (2 doses - given five months apart) or a 3 dose series (3 doses given at an interval of 0, 1 and 6 months)when you were in grade 7. Either is acceptable. Unimmunized adults require a 3 dose series.

Hepatitis B Vaccine dates: 1st _____ 2nd _____ 3rd _____ ❑ COPY OF LAB ATTACHED (MANDATORY)

AND I have submitted a copy of blood work results indicating Hepatitis B immunity (blood work must be done at least 30 days after the last dose)

Date titre drawn: _____ Result:_____ ❑ COPY ENCLOSED (MANDATORY)

If you have had the vaccine but your blood work shows you are not immune, a booster dose is required followed by a blood test to check immune status one month after the booster dose: If you are still not immune, please consult a Health Services RN.

Date booster given: _____ Signature _____ RN / MD

Date of post vaccination titre (at least 30 days after booster): _____ Result: _____ ❑ COPY OF LAB ATTACHED (MANDATORY)