On Campus BScN Learning Program
Initial 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 On Campus BScN Program 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 second 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
Proof of a past or baseline two-step Tuberculin Skin Test (TST) is mandatory. If you do not have a past test you will need to get a baseline two-step TST. If your past two step is older than 3 months, then you will need a one-step. **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 must be less than 1 year old). **AND** 2) Annual TB Surveillance letter. A copy of this letter can be found attached to the last page of this form. 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.	**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

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:** _____

VARICELLA

Instructions	Immunization/Serologic Status
Students <u>must</u> document immunity via one of the following: Documented vaccination with 2 doses (regardless of year of birth) **OR** Documented laboratory evidence of immunity Note: If titre results are non-reactive/nonimmune/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/yy) _____

<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:** _____

TETANUS/DIPHTHERIA

Instructions	Immunization/Serologic Status
Single adult dose (18 years or older) of Tdap (tetanus, diphtheria & pertussis) is required. Students must document vaccination for Tetanus & Diphtheria must be vaccinated every 10 years. To meet clearance requirements, immunity cannot expire before the next clearance cycle. It is the responsibility of the student to ensure that these boosters remain up to date after admittance into the On Campus 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: _____

Student Name: _____	Student Number: _____

MEASLES, MUMPS, RUBELLA (MMR)

Instructions	Immunization/Serologic Status
Students <u>must</u> document immunity via one of the following: Documentation of vaccination with 2 doses (regardless of year of birth) **<u>OR</u>** Documented laboratory evidence of immunity (serologic testing/bloodwork for Measles, Mumps and Rubella). Note: if titre results are non-reactive/nonimmune/indeterminate, then documentation of full vaccination is required by the School of Nursing.	**<u>MMR Vaccination</u>** Dose #1 Date (dd/mm/yyyy) _____ Dose #2 Date (dd/mm/yyyy) _____ **<u>OR</u>** **<u>Titre Results</u>** **Antibody Titre must not be taken sooner than 1 month following completion of vaccination series** **<u>Measles</u>** Date of Titre: (dd/mm/yyyy) _____ ☐ Reactive/Immune (+) ☐ Non-Reactive/Non-Immune (-) ☐ Indeterminate **<u>Mumps</u>** Date of Titre: (dd/mm/yyyy) _____ ☐ Reactive/Immune (+) ☐ Non-Reactive/Non-Immune (-) ☐ Indeterminate **<u>Rubella</u>** Date of Titre: (dd/mm/yyyy) _____ ☐ Reactive/Immune (+) ☐ Non-Reactive/Non-Immune (-) ☐ Indeterminate **<u>Note: If a booster has also been given</u>** Booster Date: (dd/mm/yyyy) _____

<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: _____

HEPATITIS B

Instructions	Immunization/Serologic Status
Students <u>must</u> provide both dates of primary series final dose and documented immunity. 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". 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. ******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. ******	**<u>Dates of vaccination:</u>** Dose #1 Date (dd/mm/yyyy) _____ Dose #2 Date (dd/mm/yyyy) _____ Dose #3 Date (dd/mm/yyyy) _____ **<u>Surface Antibody Level (Anti-HBs Titre)</u>** **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 (-) **<u>If non-reactive, student must complete full repeat series (3 doses recommended for HCPs):</u>** 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: _____

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 ONLY for students with a current or past positive TB skin test.**