FOR OFFICE USE ONLY: Date received: ________________ Information /Vaccinations Outstanding **BLUE 2009-10** 1st ☐ 2nd ☐

FORM COMPLETE:☐ _____ (Staff Initial) Date: ________________

PLEASE READ CAREFULLY: *Remember - Being ready is your responsibility !*

IF YOU ARE REGISTERED IN ONE OF THE PROGRAMS LISTED ON THIS FORM, YOU **MUST** COMPLETE THIS FORM. Students whose forms are not complete will not be able to participate in the field placements that are an essential part of each program.

Be sure to write your name clearly and include your Health Insurance Number (eg. OHIP), and the full program name.

PERSONAL INFORMATION DATA

To be completed by the student: ALL FIELDS MUST BE COMPLETE IN ORDER TO PROCESS THIS FORM

NAME: ____
Family name *given name*

PROGRAM START DATE: ________/________ Program Name: ______________________
Month / Year

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

Telephone #: ______________________ Sex: M / F Date of Birth: _____/________/________
D / M / Y

E-mail Address: ______________________

Health Card #: ______________________ Province: __________ Other Health Insurance ______________________
(Private)

PERSONAL HEALTH HISTORY:

TO BE COMPLETED BY STUDENT

1. ALLERGIES: drugs, natural (eg dust pollens etc) latex: ____

____

2. Have you had the following illnesses? If yes, give the approximate date:

Hepatitis B	❑	YES	❑	NO	Date: ____________________
Tuberculosis	❑	YES	❑	NO	Date: ____________________
Back injuries (Did you miss work?)	❑	YES	❑	NO	Date: ____________________

3. Any other significant illnesses/conditions? (Physical or Psychological) ____

____

4. Are you physically fit for your program? If not, give reasons: ____

____

The information on these forms is kept confidential within the Health Services Office. However, if your records are not complete, or should they indicate that there is a significant health risk for you in the workplace, this will be communicated to the College staff responsible for your placement. ***Failure to declare a physical or psychological health problem that endangers your ability to cope with the normal program of studies will lead to your immediate withdrawal from the program.***

I affirm that to the best of my knowledge the above statements regarding personal health history are true. I confirm that I have read the above statement and I give consent to release information as is necessary for my work placement.

______________________________ ____________________
Signature of Student *Date*

IMMUNIZATION HISTORY - STEPS TO FOLLOW: PLEASE READ CAREFULLY

- The required tuberculosis testing/immunizations*/ blood work is available through the College's Health Services at little or no cost. *Note: Hepatitis B vaccines are not free, but are available at a reduced cost.
- If your doctor fills out this form for you, you might be charged a fee in his/her office.
- Copies of immunization records are acceptable.
- **Computerized records of childhood vaccinations** can be obtained by you by phoning your Public Health Department. Contact information for all Ontario Public Health Departments can be found on the web site: www.health.gov.on.ca/english/public/contact/phu/phuloc_mn.html For those Students from Ottawa-Carleton High Schools, the Public Health Unit number is **613-580-6744 Ex 24108**. For students attending the Woodroffe Campus, records can be faxed directly to **613-727-7793**.
- If you are unable to obtain records, please consult with an Algonquin College Health Services Nurse.
- Bring or mail forms to the appropriate campus:

Health Services Office, Room C141
Algonquin College
1385 Woodroffe Ave.
Ottawa, ON K2G 1V8

Health Services Office
Algonquin College
315 Pembroke Street
Pembroke, ON K8A 3K2

Health Services Office
Algonquin College
7 Craig Street
Perth, ON K7H 1X7

IMMUNIZATION FORM

BLUE 2009-10

NAME:____ DATE OF BIRTH _____/_______/_____ PROG ________
family name given name day / month / year

IMMUNIZATIONS:

* PLEASE SUBMIT COPIES OF YOUR VACCINATION RECORDS *

❑ COPY ENCLOSED ❑ TO FOLLOW ❑ RECORDS NOT AVAILABLE **If records are not available, please consult Health Services** ☐

1. **TETANUS DIPTHERIA VACCINE:** Is primary series complete?: ❑ YES Date of last injection (must be within the last 10 years) ________________
or ❑ NO If NO, an adult primary series of 3 doses is required

Date of first dose / booster dose: ____________________________ by__________________ RN / MD

2nd dose (2 months after 1st visit): ____________________________ by__________________ RN / MD

3rd dose (6-12 months after 2nd visit): ____________________________ by__________________ RN / MD ☐

2. **POLIO VACCINE:** Is primary series complete? ❑ YES Date of last injection________________
or ❑ NO If NO, an adult primary series of 3 doses is required

Date of first dose / booster dose: ____________________________ by__________________ RN / MD

2nd dose (2 months after 1st visit): ____________________________ by__________________ RN / MD

3rd dose (6-12 months after 2nd visit): ____________________________ by__________________ RN / MD ☐

3. **VARICELLA (CHICKEN POX) IMMUNITY:** A blood test result for Varicella Antibodies is required:

Date drawn: _____________ Result ❑ IMMUNE ❑ NON-REACTIVE ❑ COPY ENCLOSED ❑ TO FOLLOW

IF YOU ARE NOT IMMUNE, vaccination is required.

Dose #1 Date: _____________ Varicella 0.5 cc SC L R Lot # _____________ by ______________________RN/MD

Dose #2 * Date: _____________ Varicella 0.5 cc SC L R Lot # _____________ by ______________________ RN/MD ☐

* (4 - 8 weeks after 1st dose)

IMMUNIZATION FORM

NAME:____ DATE OF BIRTH _____/_______/_____ PROG ________
family name given name day / month / year

4. **DOCUMENTED HISTORY OF TWO DOSES OF MMR:** NOTE: For students who received a second measles only vaccine, blood work demonstrating immunity to Measles, Mumps and Rubella is required.

Date of 1st MMR: ________________ and Date of 2nd MMR: ________________

OR Submit a copy of blood test results for Measles, Mumps and Rubella Antibodies: ❑ COPY ENCLOSED ❑ TO FOLLOW

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. **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. **NOTE: TB testing must be completed prior to any live vaccines such as MMR, OPV or Varicella boosters.** A TB test is invalid if it is given in the 30 day period following the administration of any of these 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 Xray**

STEP ONE:

Date: ________________ L R Forearm Result __________mm TB test is positive (>10 mm) proceed to chest X-ray

Lot: ___________________________ TB test is negative (<10mm) repeat TB test in 1– 3 weeks

STEP TWO:

Date: ________________ L R Forearm Result __________mm TB test is positive (>10 mm) proceed to chest X-ray

Lot: ___________________________ 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 (ie: within 6 months of your program start date) ❑ COPY ENCLOSED ❑ TO FOLLOW

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

____ ☐

OFFICE USE ONLY:

2nd year Date: ________________ 0.1 cc ID L R Forearm Lot: _________________ Result ________mm ____________

3rd year Date: ________________ 0.1 cc ID L R Forearm Lot: _________________ Result ________mm ____________

6. **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.

I have received the Hepatitis B Vaccine: Dates: 1st ________________

2nd ________________

3rd ________________ Signature____________________________

AND I have submitted a copy of blood work results indicating Hepatitis B immunity

Date titre drawn: ________________ Result:__________________ ❑ COPY ENCLOSED ❑ TO FOLLOW

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:

Date booster given: ______________________________________ Signature____________________________

Date titre drawn: ________________ Result:__________________ ❑ COPY ENCLOSED ❑ TO FOLLOW ☐

THIS FORM IS TO BE COMPLETED IF YOU ARE IN ONE OF THE FOLLOWING PROGRAMS:

COURSE
Advance Care Paramedic
Cardiac Diagnostics
Clinical Intensive Orientation to Nursing in Ontario
Dental Assist's (Level I & II)
Dental Hygiene
Food and Nutrition Management
Orientation to Nursing in Ontario for Nurses
Orientation to Nursing in Ontario for Practical Nurses
Paramedic
Polysomnography
Practical Nursing
Practical Nursing – Foreign Trained Nurse
Recreation For Older Adults
Respiratory Therapy
RPN Certificate to RPN Diploma Bridging program
RPN Operating Room Nurse
RN Critical Care Nursing
RN Emergency Nursing
RN Operating Room
RN Palliative Care - Multidiscipline

Returning students will require TB testing to be updated annually and proof of completion of your Hepatitis B vaccines. The returning Student form can be downloaded from the Health Services Entry Immunization site.