

FOR OFFICE USE ONLY: Date received: \_\_\_\_\_

Information /Vaccinations Outstanding **GREEN 09-10**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 namePROGRAM START DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Program Name: \_\_\_\_\_  
Month I YearAddress: \_\_\_\_\_  
Street City Province Postal codeTelephone #: \_\_\_\_\_ Sex: M / F Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
D I M I 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](http://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**

GREEN 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 DIPHTHERIA 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: Have you had Chicken Pox or Shingles?  YES  NO  UNSURE  
IF NO OR UNSURE: A blood test for Varicella Antibodies is required:  
Date drawn: \_\_\_\_\_ Result  IMMUNE  NON-REACTIVE  COPY ENCLOSED  TO FOLLOW  
IF YOU ARE NOT IMMUNE, vaccination may be required. Please discuss with one of our Health services Nurses.

OFFICE USE ONLY; Dose #1 Date: \_\_\_\_\_ Varicella 0.5 cc SC L R Lot # \_\_\_\_\_ by \_\_\_\_\_ RN/MD  
4-6 weeks after dose #1: Dose #2 Date: \_\_\_\_\_ Varicella 0.5 cc SC L R Lot # \_\_\_\_\_ by \_\_\_\_\_ RN/MD

# 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 1<sup>st</sup> MMR: \_\_\_\_\_ and Date of 2<sup>nd</sup> MMR: \_\_\_\_\_

OR Submit a copy of blood test results for Measles, Mumps and Rubella Antibodies: **1** COPY ENCLOSED **1** TO FOLLOW

Date drawn: _____	Results:	Measles	<b>1</b>	Reactive	<b>1</b>	Non- Reactive
		Mumps	<b>1</b>	Reactive	<b>1</b>	Non- Reactive
		Rubella	<b>1</b>	Reactive	<b>1</b>	Non- Reactive

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 (  $\geq 10$  mm) proceed to chest X-ray  
Lot: \_\_\_\_\_ TB test is negative (  $< 10$  mm) repeat TB test in 1– 3 weeks

**STEP TWO:**

Date: \_\_\_\_\_ L R Forearm Result \_\_\_\_\_ mm TB test is positive (  $\geq 10$  mm) proceed to chest X-ray  
Lot: \_\_\_\_\_ TB test is negative (  $< 10$  mm) 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) **1** COPY ENCLOSED **1** TO FOLLOW

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

OFFICE USE ONLY:

2<sup>nd</sup> year Date: \_\_\_\_\_ 0.1 cc ID L R Forearm Lot: \_\_\_\_\_ Result \_\_\_\_\_ mm \_\_\_\_\_

3<sup>rd</sup> year Date: \_\_\_\_\_ 0.1 cc ID L R Forearm Lot: \_\_\_\_\_ Result \_\_\_\_\_ mm \_\_\_\_\_

6. HEPATITIS B VACCINE is MANDATORY for Child and Youth Worker, Community and Justice Services, Developmental Service Worker, Early Childhood Education, Massage Therapy, Personal Care Assistant, Personal Support Worker, Pre-Service Firefighter, RPN Administration of Medications, Social Service Worker and Sterile Supply Processing programs and is strongly recommended for all students. 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: 1<sup>st</sup> \_\_\_\_\_  
2<sup>nd</sup> \_\_\_\_\_  
3<sup>rd</sup> \_\_\_\_\_

Signature \_\_\_\_\_

OR I have submitted a copy of blood work results indicating Hepatitis B immunity **1** COPY ENCLOSED **1** TO FOLLOW

Date titre drawn: \_\_\_\_\_ Result: \_\_\_\_\_ Signature \_\_\_\_\_

OR I have not yet received the Hepatitis B vaccine and will start the vaccination process during the first month of my program. Signature \_\_\_\_\_

OR Hepatitis B vaccine is not mandatory for my program and I have decided not to have Hepatitis B vaccine. I understand that I assume responsibility for any risks involved from exposure to Hepatitis B during my studies. Signature \_\_\_\_\_

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

COURSE
Child and Youth Worker
Community and Justice Services
Dementia Studies - Multidiscipline
Developmental Services Worker
Early Childhood Education
Early Childhood Education (Intensive)
Gerontology - Multidiscipline
Massage Therapy
Patient Care Assistant Program
Personal Support Worker
Pre-Service Firefighter Education and Training
RPN Administration of Medications
Social Service Worker
Social Service Worker (Intensive Delivery)
Sterile Supply Processing
Working with the Aged - Multidiscipline
Working with Dementia - Multidiscipline Clients
Working with the Terminally Ill - Multidiscipline

Returning students will require TB testing to be updated annually and proof of completion of your hepatitis B vaccines (if mandatory for your program). Returning Student Form can be downloaded from the [Health Services Entry Immunization](#) site.