



OFFICE USE ONLY
 CLEARED DATE:
 Date: ____/____/____
 year month day

IMMUNIZATION RECORD FORM FOR FULL-TIME, PART-TIME, CON-ED STUDIES

***Please complete ALL information requested on this page only and return completed to your campus Health Centre along with your Immunization Card and Lab test results for proof**

Students in the following programs will need to have their immunization record reviewed and updated annually

- Early Childhood Education (ECE) (Full-Time Day & Con-Ed)
- Educational Assistant (EA) (Diploma, Intensive)
- Practical Nursing (PN)
- Personal Support Worker (PSW)
- Pharmacy Technician

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.

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

FULL-TIME STUDIES

PART-TIME STUDIES (DAYTIME)

PART-TIME STUDIES (CONTINUING EDUCATION)

Name _____ **Gender:** M F **Date of Birth** ____ (year) ____ (month) ____ (day)
 Last First

Program _____ **Student Number** _____ **Email Address** _____

Currently in Year (please circle) 1 2 3 4 5 **Program Length** _____ (# of years)

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 RETREIVE 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.

Copy Received (Student's Signature) : _____

***NOTE-ALL INFO. BELOW TO BE COMPLETED BY A SHERIDAN HEALTH CENTRE NURSE**

Students **WILL NOT BE ALLOWED** on placement until **ALL** immunization information is completed and a *Certificate of Clearance* is issued by the Health Centre. These **COMPULSORY** requirements are based on recommendations established by the Ontario Hospitals Act, Days Nursery Act, Canadian Immunization Standards, Health Canada and the both the Halton and Peel Medical Officers of Health.

1. **Tdp (Tetanus,Diphtheria,Polio) primary series:** Yes Required every 10 years: Date of Td or Tdap: _____ **proof required*
If you have no proof of primary series, 3 doses of vaccine are required.
Date: #1 _____ (Tdap / Td) #2 _____ (4-8 wks after 1st) (Tdap / Td) #3 _____ (6-12mths after 2nd) (Tdap / Td)
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). ****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*
OR
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 VACCINE-(COMPULSORY for PN & Pharmacy Programs. HIGHLY recommended for ECE & PSW program)**
Twinrix / Engerix 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.
#1. Date: _____ #2. Date: _____ and/or #3. Date: _____ **proof required*
OR
Hepatitis B Booster 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 & 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 VACCINE – (Compulsory for all PN, PSW & Pharmacy Programs) Date: _____ **proof required***

*The statements given above are true to the best of my knowledge and belief. I, _____ (print name), 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.

Student's Signature: _____

Date: _____

Revised September, 2011