

NIAGARA HEALTH SYSTEM
Occupational Health & Safety Department
Communicable Disease Surveillance Program

Section 1 to be Completed by Student

School:		Program:	
Name:	_____	Classification:	_____
Hospital Site:	_____	Department:	_____
D.O.B.	_____	Home Phone:	_____
Address:	_____		

The Communicable Disease Protocols require that hospitals must have document proof of immunization and/or history of specific communicable disease for all persons, including employees, physicians, volunteers, students and contract workers carrying on activities in patient care areas of the Hospital. This requirement must be met prior to commencing the first day of work/placement. **If you have been fitted for an N95 respirator mask, please provide proof of the date tested and type of mask you were passed on.**

Please provide this information to the appropriate Occupational Health & Safety Department where placement will occur. Please see attached lists of sites.

I authorize the release of the following information to the Occupational Health & Safety Department and Student Resources.

Signature _____ Date _____

Section 2 REQUIRED (Questions # 1, 2, 3, 4 and 5 must be completed)

Section 2 must be Completed by Health Professional

1. Is there a history of varicella (chickenpox) or zoster (shingles) Yes: No:

If **NO** or **UNKNOWN**, lab screening for varicella is required. _____ _____
Date Titre

2. Is this person rubella immune? Yes: No:

Persons will be considered immune if they have:

- Laboratory evidence of rubella immunity.
- Documented evidence of immunization with live rubella vaccine on or after their first birthday

_____ _____
Date Titre

_____ _____
Date Vaccinated

If a titre is not available and the person has not been vaccinated **one or both must be completed** to prove immunity prior to entrance into the Hospital for reasons of patient safety.

3. Is there evidence of measles immunity? Yes: No:

Only the following will be accepted as proof of immunity:

- The person was born before 1970; or
- Physician documented history of clinical measles (report signs and symptoms consistent with clinical measles case definition); or
- Laboratory evidence of measles immunity; or
- Documentation of receipt of 2 doses of live measles virus vaccine on or after first birthday.

_____ _____
Date Titre

_____ _____
Date Vaccinated

4. Is there evidence of mumps immunity? Yes: No:

Only the following will be accepted as proof of immunity:

- The person was born before 1970; or
- Laboratory evidence of measles immunity; or
- Documentation of receipt of 2 doses of live measles virus vaccine on or after first birthday.

_____ _____
Date Titre

_____ _____
Date Vaccinated

If none of the above apply, the individual must be offered a measles vaccination. The trivalent MMR vaccine is recommended.
For reasons of patient safety, proof of immunity to measles is required.

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Section 2 REQUIRED (Questions # 1, 2, 3, 4 and 5 must be completed)

4. Documentation of a Two-step (2-Step) tuberculin skin test is also required. An initial tuberculin skin test (Mantoux, 5TU PPD) is given. If this test result is 0 - 9 mm of induration, **a second test is given in the opposite arm at least one week and no more than four weeks after the first.**

If it has been over 12 months since the last 2-step test, then a one-step test is also required.

Tuberculin Skin Testing

1) Date Given: _____	Given By: _____	Date Read: _____
Read By: _____	Result: _____	(_____ mm. Induration)
2) Date Given: _____	Given By: _____	Date Read: _____
Read By: _____	Result: _____	(_____ mm. Induration)
3) Date Given: _____	Given By: _____	Date Read: _____
Read By: _____	Result: _____	(_____ mm. Induration)

TB test results MUST BE recorded in both words and numbers (e.g. Negative 0 mm induration)

Persons who have had previous B.C.G. vaccine should be assessed as above. Persons who are tuberculin positive should have a chest x-ray if they have:

- Never been evaluated for a positive TB test or tuberculosis;
- Had a previous diagnosis of TB and have never received adequate treatment for TB; or
- Pulmonary symptoms that may be due to TB.

The physician must report all positive TB skin tests to the Public Health Department.

Date of Chest X-ray: _____ Result: _____

Section 2 RECOMMENDED

6. Has the person received the Influenza Vaccine? _____
Date Vaccinated

7. When was the person last immunized for tetanus-diphtheria? _____
Date Vaccinated

8. Date of last pertussis immunization (i.e. Adacel or Tdap)? _____
Date Vaccinated

8. Has this person received the Hepatitis B Vaccine? **Yes:** **No:**

Date of 1st Dose: _____
 Date of 2nd Dose: _____
 Date of 3rd Dose: _____

Health Professional's Signature: _____

Name of Health Care Professional: _____

Address: _____ Please Print Telephone: _____

_____ Date: _____

Section 2 must be Completed by Health Professional