IMMUNIZATION RECORD & SEROLOGIC STATUS FORM

Queen's University, School of Nursing

PART A: Healthcare Professional Information & Declaration

This section is to be completed by a healthcare professional only.

Name of Healthcare Professional Completing Form: (please print)	**Professional Designation:**
Address:	
Telephone #:	**Fax #:**

I confirm that the below information provided on this form is correct.

Signature of Healthcare Professional:	**Initials of Healthcare Professional:**
Date: (yyyy/mm/dd)	

Signature of Healthcare Professional:	**Initials of Healthcare Professional:**
Date: (yyyy/mm/dd)	

PART B: Student Authorization

I give my consent that the information on this form may be shared as required with Queen's University, School of Nursing and with the clinical facility teaching and administrative staff. Without completing this section, I understand that my form cannot be processed by the School of Nursing.

Student Name: (please print)	
Student Date of Birth: (yyyy/mm/dd)	
Student Number:	
Student Signature:	

Student Name: _____
Student DOB (yyyy/mm/dd): _____

PART C: Immunizations, Serologic Status & Vaccinations

A healthcare professional is to complete the remainder of this form, not the student.

HEPATITIS B *All of Section A must be completed*

SECTION A		
Hep B Series (2 doses if completed in Grade 7)	**Date** (yyyy/mm/dd)	**Healthcare Professional Initials**
Dose #1		
Dose #2		
Dose #3		
Complete titre to determine Surface Antibody Level (Anti-HBs): Reactive/Immune (+) Non-reactive/non-immune (-)		
If Non-Reactive: HBsAg is **positive:** ☐ or **negative**: ☐		

SECTION B		
If Non-Immune, give:	**Date** (yyyy/mm/dd)	**Healthcare Professional Initials**
Dose #4		
Complete titre to determine Surface Antibody Level (Anti-HBs): Reactive/Immune (+) Non-reactive/non-immune (-)		
If non-immune, complete second series: **Dose #5**		
Dose #6		
Complete titre to determine Surface Antibody Level (Anti-HBs): Reactive/Immune (+) Non-reactive/non-immune (-)		

ANNOTATIONS:

- Students must provide documentation of Hepatitis B vaccinations
- Serology for surface antibody levels (Anti-HBs) must be done to show immunity for all students
- Students not showing immunity to Hepatitis B after vaccination are required to receive the Hepatitis B Surface Antigen (HBsAg) test
- Repeat titres must be drawn no earlier than 1 month from the date of the last vaccination

Student Name: _____
Student DOB (yyyy/mm/dd): _____

INFLUENZA *Recommended – Not Required*

Date (yyyy/mm/dd)	Healthcare Provider Initials

ANNOTATIONS:

- The influenza vaccination is not usually available until October and takes two weeks to become effective
- An annual influenza vaccination should be done as soon as the vaccine becomes available.

MEASLES, MUMPS & RUBELLA (MMR)

Measles Titre	Date (yyyy/mm/dd/)	Healthcare Provider Initials
Reactive/Immune (+) Non-reactive (non-immune) (-)		

Mumps Titre	Date (yyyy/mm/dd/)	Healthcare Provider Initials
Reactive/Immune (+) Non-reactive (non-immune) (-)		

Rubella Titre	Date (yyyy/mm/dd/)	Healthcare Provider Initials
Reactive/Immune (+) Non-reactive (non-immune) (-)		

or

	Date (yyyy/mm/dd)	Healthcare Provider Initials
MMR Dose #1		
MMR Dose #2		

ANNOTATIONS:

- If non-reactive/non-immune, immunization & documentation submission is required

  or

- Students must provide evidence of two doses of measles, mumps, rubella (MMR) vaccine

MENINGOCOCCAL VACCINE [Men-C-C or Men-C-ACYW-135] *Recommended*

Date (yyyy/mm/dd)	Healthcare Provider Initials

Polio Series	Date (yyyy/mm/dd)	Healthcare Professional Initials
Dose #1		
Dose #2		
Dose #3		
Dose #4		
Dose #5		

ANNOTATIONS:

- Students are required to provide documentation of a complete series of polio vaccine
- Polio vaccine series consists of 5 doses for children up to 6 years old, and 3 doses if primary series was started after age 7 (adult dose). Four doses are sufficient if one was given after age 4.

TETANUS/DIPHTHERIA

	Date (yyyy/mm/dd)	Type of Vaccine Given	Healthcare Professional Initials
Dose #1			
Dose #2			
Dose #3			

If applicable:

Dose #4			
Dose #5			
Dose #6			

ANNOTATIONS:

- In addition to a complete primary series (or adult catch-up series), documentation of a dose of tetanus and diphtheria-containing vaccine received within the last 10 years is required

PERTUSSIS

Date (yyyy/mm/dd)	Type of Vaccine Given	Healthcare Professional Initials

ANNOTATIONS:

- Documentation of the most recent dose of pertussis-containing vaccine is required
- A dose of pertussis immunization is required for the Obstetrical and Pediatric Clinical Rotations. rotation. If the student is over the age of 18 and has not yet received a dose of pertussis-containing vaccine in adulthood, the vaccine must be received prior to year 3 of the 4-yr track of study, or prior to commencing year 1 of the AST track of study unless the interval since the adolescent pertussis dose is <2 years.

Student Name: _____
Student DOB (yyyy/mm/dd): _____

2-step Tuberculin Skin Test (TST) Documentation Required:

	Date Given (yyyy/mm/dd)	**Date Read** (yyyy/mm/dd)	**mm induration**	**Healthcare Professional Initials**
Step 1				
Step 2				

If a 2-step test was completed once in a lifetime, but was done more than 12 months ago, record these results above **AND** provide documentation of a single step TST (done within the last 12 months).

	Date Given (yyyy/mm/dd)	**Date Read** (yyyy/mm/dd)	**mm induration**	**Healthcare Professional Initials**
Step 1				

ANNOTATIONS:

- A valid 2-step TST occurs when steps 1 and 2 are done 1-4 weeks apart
- Annual 1-step TSTs are required throughout the duration of the program
- Results must be recorded as millimetres of induration (NOT "positive" or "negative")
- If either TST is positive, this must be reported to the School and the following are required:
  - a chest x-ray report
  - results of a medical assessment by a healthcare professional
  - results of a symptom check by a healthcare professional
  - positive findings are reportable – please refer student to the TB Clinic at KGH - HDH site

VARICELLA

Titre	**Date** (yyyy/mm/dd)	**Healthcare Professional Initials**
Reactive/Immune (+) Non-reactive (non-immune) (-)		

or

	Date (yyyy/mm/dd)	**Healthcare Professional Initials**
Dose #1		
Dose #2		

ANNOTATIONS:

- A history of disease alone is insufficient evidence of immunity to varicella unless accompanied by laboratory confirmation
- If non-reactive/non-immune, immunization is required with documentation submitted to the School

COVID-19 VACCINE

	Date (yyyy/mm/dd)	Healthcare Professional Initials
Dose #1		
Dose #2		
Booster		
Booster		

Novel coronavirus disease 2019 (COVID-19) vaccination is required for clinical teaching activities and clinical placements. Learners who choose not to have COVID-19 vaccination should be notified that university and hospital policies may preclude them from clinical teaching and/or clinical placements that are curricular requirements