



The Education Centre
Campus Health Centre, Room C211
 P.O. Box 5001, North Bay, ON P1B 8K9
 Tel: (705) 474-7600, ext. 5261 Fax: 495-7909

COMMUNICABLE DISEASE SCREENING PROTOCOL

Health Sciences

(BScN, Community and Justice Services, Dental Hygiene, Mental Health and Addiction Worker, Personal Support Worker, Practical Nurse, Respiratory Therapy)

Last Name	First Name	Middle Name
Student Number (Canadore Banner ID Number)	Program	
Date of Birth (D/M/Y)	Health Card Number	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Health Card Expiry Date if Applicable	

Permanent Address:

Street	City	Postal Code	Telephone
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Address While Attending School:

Street	City	Postal Code	Telephone
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Person to Contact in Case of Emergency:

Name	Telephone
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Family Physician:

Name	Telephone and Fax Number
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I authorize the Health Centre to release my clearance status for placement purposes to my program coordinator.

Student Signature	Date
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SECTION BELOW FOR ADMINISTRATIVE PURPOSES ONLY

Communicable Disease Year 1 Clearance	Communicable Disease Year 2 Clearance	Communicable Disease Year 3 Clearance	Communicable Disease Year 4 Clearance
_____ Date	_____ Date	_____ Date	_____ Date

Complete this page (page 2) if the student has no history of a positive TB Mantoux test

Tuberculosis Screening Test (TST)

Student requirements:

- * A 2-Step Mantoux test **OR** two documented one step TST's at any time.
AND
- * One of the TST's must be within this calendar year.

2-Step Mantoux Test	Date Given	Date Read (Must be within 48-72 hours)	Induration	Interpretation (If positive, complete Part B)	Health Care Provider Initial
Step 1	____/____/____ YY MM DD	____/____/____ YY MM DD	_____ mm		
Step 2	____/____/____ YY MM DD	____/____/____ YY MM DD	_____ mm		

Complete below if the student has two documented one step TST's at any time

2-Step Mantoux Test	Date Given	Date Read (Must be within 48-72 hours)	Induration	Interpretation (If positive, complete Part B)	Health Care Provider Initial
TST 1	____/____/____ YY MM DD	____/____/____ YY MM DD	_____ mm		
TST 2	____/____/____ YY MM DD	____/____/____ YY MM DD	_____ mm		

Complete only if any of the above documented TST's are not within this calendar year

Single Step Mantoux Test	Date Given	Date Read (Must be within 48-72 hours)	Induration	Interpretation (If positive, complete Part B)	Health Care Provider Initial
Single Step Year 1	____/____/____ YY MM DD	____/____/____ YY MM DD	_____ mm		
Single Step Year 2	____/____/____ YY MM DD	____/____/____ YY MM DD	_____ mm		
Single Step Year 3	____/____/____ YY MM DD	____/____/____ YY MM DD	_____ mm		
Single Step Year 4	____/____/____ YY MM DD	____/____/____ YY MM DD	_____ mm		

Complete this section (page 3) only if the student has had a positive TB Mantoux test

Positive Mantoux Test			
Date Given	Date Read	Induration in mm	Health Care Provider Initials
____/____/____ YY MM DD	____/____/____ YY MM DD		

Chest x-ray and Sputum Testing		
Chest X-ray Date (Must be in current year)	Chest X-ray Result	Health Care Provider Initials
____/____/____ YY MM DD		

Sputum Date YY/MM/DD	Sputum Results	Health Care Provider Initials
1.		
2.		
3.		

Positive TB Test Annual Screening				
Chest x-ray Date YY/MM/DD	Chest x-ray Result	Annual Symptom Review	Recommendations	Health Care Provider Initials

Measles, Mumps and Rubella (MMR)

Record of two MMR vaccinations (must be at least 1 month apart)	____/____/____ YY MM DD	Health Care Provider Initials
	____/____/____ YY MM DD	

OR Demonstrated immunity to Measles, Mumps and Rubella

	Serology Date	Result	Health Care Provider Initials
Measles	____/____/____ YY MM DD		
Mumps	____/____/____ YY MM DD		
Rubella	____/____/____ YY MM DD		

Varicella/Zoster (Chicken Pox/Shingles)

Documented History of Chicken Pox or Shingles?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Health Care Provider Initials

OR (demonstrated immunity to Varicella)

Date of Immune Status Testing	Result	Health Care Provider Initials
____/____/____ YY MM DD		

OR (2 doses of Varicella Vaccine)

Dose	Vaccine Name	Date	Health Care Provider Initials
1		____/____/____ YY MM DD	
2 (Minimum 28 days after Vaccine #1)		____/____/____ YY MM DD	

Tetanus, Diphtheria, Acellular Pertussis (Tdap – Adacel)

Immunization	Date	Health Care Provider Initials
Tetanus (Td or Tdp)	____/____/____ YY MM DD	
Adacel (Tdap)	____/____/____ YY MM DD	

Hepatitis B

Hepatitis B Immunization Series (2 or 3 dose series)

(Protocol provides for conditional clearance after Dose #2 so students may start clinical placement.)

		Health Care Provider Initials		
Dose 1	____/____/____ YY MM DD			
Dose 2	____/____/____ YY MM DD			
HBsAb (anti-HBs) Titre	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Date ____/____/____ YY MM DD</td> <td>Result _____</td> </tr> </table>	Date ____/____/____ YY MM DD	Result _____	
Date ____/____/____ YY MM DD	Result _____			
Dose 3	____/____/____ YY MM DD			
HBsAb (anti-HBs) Titre	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Date ____/____/____ YY MM DD</td> <td>Result _____</td> </tr> </table>	Date ____/____/____ YY MM DD	Result _____	
Date ____/____/____ YY MM DD	Result _____			
<p><u>Part B:</u> Continue with 3-dose immunization series if titre result non-immune (<10mIU/mL)</p> <p><i>Serology may be taken after first dose of second series to assess immunity if original series was completed more than 6 months prior to a negative HBsAB Test</i></p>				
Dose 4	____/____/____ YY MM DD			
HBsAb (anti-HBs) Titre	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Date ____/____/____ YY MM DD</td> <td>Result _____</td> </tr> </table>	Date ____/____/____ YY MM DD	Result _____	
Date ____/____/____ YY MM DD	Result _____			
Dose 5	____/____/____ YY MM DD			
Dose 6	____/____/____ YY MM DD			
HBsAb (anti-HBs) Titre	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Date ____/____/____ YY MM DD</td> <td>Result _____</td> </tr> </table>	Date ____/____/____ YY MM DD	Result _____	
Date ____/____/____ YY MM DD	Result _____			

Health Care Provider Information

Every Health Care Provider (HCP) who completes any part of this form must complete this section to ensure the Campus Health Centre is able to contact her/him in the event clarification is required regarding documentation initialed by the HCP.

Health Care Provider #1

Name: _____ **Initials:** _____
Address: _____ **Telephone:** _____
_____ **Profession:** _____
Signature: _____ **Date:** _____

Health Care Provider #2

Name: _____ **Initials:** _____
Address: _____ **Telephone:** _____
_____ **Profession:** _____
Signature: _____ **Date:** _____

Health Care Provider #3

Name: _____ **Initials:** _____
Address: _____ **Telephone:** _____
_____ **Profession:** _____
Signature: _____ **Date:** _____

If more than three different Health Care Providers have participated in the completion of the form, please provide the requested information on the reverse of this page. Thank you.