NORTHWESTERN POLYTECHNIC

School of Health
780-539-2750 nursing@NWPolytech.ca

STUDENT IMMUNIZATION CLEARANCE FORM

Full Legal Name: _____

Date Of Birth: _____

Country of Birth: _____

**** COPIES OF ALL IMMUNIZATION RECORDS AND TEST RESULTS MUST BE SUBMITTED WITH THIS FORM**

VACCINE	REQUIREMENTS	RESULTS
TETANUS, DIPHTHERIA	• Primary series of 3 or more documented doses of tetanus and diphtheria AND a reinforcing dose in the last 10 years. The reinforcing dose will often be administered with the adult pertussis vaccination in the form of a dTap, Tdap, Boostrix® or Adacel®. • If the student has no documentation – complete a primary series of 3 doses at appropriate intervals. The primary series should include one dose of dTap (>18 years) and 2 doses of Td vaccine.	Document the **last three** tetanus/diphtheria containing immunizations: 1. _____ (previous dose) 2. _____ (previous dose) 3. _____ (**LAST** dose received) **the last dose must be within the last 10 years**
PERTUSSIS	• 1 dose of acellular pertussis vaccine as an adult (**on or after 18 years of age**). If the student has no documentation, give 1 dose of dTap, regardless of the interval since the last dose of Td.	Date of last **dTap** (must be ≥18 years): _____
VARICELLA	• 2 doses of varicella-containing vaccine after 12months of age at appropriate intervals. Students who have 1 dose of varicella containing vaccine should be offered a second dose. **OR** • POSITIVE Varicella IgG serology results. • If Varicella IgG results are negative or indeterminate – vaccination is required. Adults need 2 doses with a minimum interval of 3 months between doses. • **Serology after vaccination is not recommended.**	**Varicella:** Dose #1: _____ Dose #2: _____ **OR** Varicella Serology: RESULTS MUST BE ATTACHED Date:_____ Result: ❑ POSITIVE ❑ NEGATIVE ❑ N/A
TUBERCULOSIS TESTING	• 1-step TST result in millimeters within **12 months** of the program start date. • BCG vaccination is NOT a contraindication to a TST. • A Chest X-Ray without written documentation of a positive TST in millimeters will **NOT** be accepted. • If there is documentation of a positive TST in millimeters– only a Chest X-Ray is required within **6 months** of the program start date. REPORT MUST BE ATTACHED.	Date of TST: _____ Date of Reading: _____Result: ____mm **If required:** Chest X-Ray Date: _____ Result: ❑ NORMAL ❑ ABNORMAL ❑ N/A Referral to TB Services? ❑ YES ❑ NO

COVID	• Annual Requirement Recommended	**Primary Series:** 1. _____ 2. _____ Last Dose: _____
INFLUENZA	• Annual Requirement Recommended	Last Dose: _____
MEASLES, MUMPS & RUBELLA	• 2 valid doses of measles-containing vaccine after12 months of age • 2 valid doses of mumps-containing vaccine after12 months of age • 1 valid dose of rubella-containing vaccine after 12 months of age is legislated under the Alberta Public Health Act. • Serological testing to determine immunity to measles, mumps, and/or rubella should not be done for students who lack documentation	**Measles:** Dose #1: _____ Dose #2: _____ **Mumps:** Dose #1: _____ Dose #2: _____ **Rubella:** Dose #1 _____ Additional Doses:_____
HEPATITIS B	• **Documentation of a complete Hepatitis B immunization series is REQUIRED** for all students. Usually, this is a 3 dose series, however, a valid 2 dose or 4 dose series will also be accepted if it meets the appropriate timing intervals. • **Positive Anti-HBs will not be accepted if there is an incomplete or absent record of immunization** except for students who are immune due to natural immunity or students with Hepatitis B infection (those with a positive Anti- HBc and/or HBsAg) • **Students who have a positive Anti-HBs, but no documentation or incomplete documentation of a complete Hepatitis B vaccine series, are required to receive a complete Hepatitis B immunization series to ensure long term immunity.**	**Hepatitis B Vaccination:** 1. _____ 2. _____ 3. _____ Additional Doses: 4. _____ 5. _____ 6. _____ 7. _____

HEPATITIS B BLOOD TESTING	• Refer to the attached algorithms for additional information (Appendix A, B & C) • The Hepatitis B serology recommendations for health care students differ based on the students' risk of past Hepatitis B infection ***Not at risk of past infection:*** an Anti-HBs serology is required ***At risk of past infection:*** an Anti-HBs, Anti-HBc & HBsAg are required. • A student ***at risk*** *of past infection* with a primary series of Hep B immunization, a negative Anti- HBc, a negative HBsAg and a positive Anti-HBs (>10U/L) is considered immune • A student ***at risk*** *of past infection* with a POSITIVE Anti-HBc and/or HBsAg requires a physician letter explaining the results • A student ***not at risk*** *of past infection*, that has a primary series of Hep B immunization, **AND** an Anti-HBs that is positive (≥10U/L), is considered immune • A student with a primary series of Hep B immunization, and an Anti-HBs that is low (<10U/L) that was checked **GREATER than 6 months** from their last Hep B vaccination should receive a booster dose and repeat Anti-HBs in 1- 6 months. If Anti-HBs remains low, 2 more doses of Hep B vaccine (administered at appropriate intervals) is required. Repeat Anti-HBs in 1-6 months after the last dose. If Anti-HBs remains low, the student is considered a non-responder and no further vaccination is recommended. A HBsAg should be ordered (if the student is *not at risk of past infection*) and a letter from a physician should be provided explaining the students' Hep B status. A student with a primary series of Hep B immunization, and an Anti-HBs that is low (<10U/L) that was checked **LESS than 6 months** from their last Hep B vaccination, should receive a second complete series of Hepatitis B vaccine (3 doses at appropriate intervals). After the final dose, repeat Anti-HBs in 1-6 months. If Anti-HBs remains low, the student is considered a non-responder and no further vaccination is recommended. A HBsAg should be ordered (if the student is *not at risk of past infection*) and a letter from a physician should be provided explaining the students' Hep B status.	❑ **Student is NOT AT RISK of past infection** **OR** ❑ **Student is AT HIGH-RISK of past infection** - *students who have immigrated to Canada from a Hep B endemic country (see Appendix A), those who have received repeated blood transfusions, those with a history of dialysis, and those with lifestyle risks of infection.* **Mandatory Serology:** *Required for all students* **Anti-HBs:** RESULTS MUST BE ATTACHED Date: _____ Result: _____ Interpretation: ❑ POSITIVE ❑ NEGATIVE **If required:** **Anti-HBc:** RESULTS MUST BE ATTACHED *Required for those students at high-risk of past Hep B infection* Date: _____ Result: ❑ POSITIVE ❑ NEGATIVE ❑ N/A **HBsAg:** RESULTS MUST BE ATTACHED *Required for those students at high-risk of past Hep B infection or those considered non-responders to Hep B immunization* Date: _____ Result: ❑ POSITIVE ❑ NEGATIVE ❑ N/A **Letter from physician explaining results:** *Required for students who have a positive Anti-HBc, a positive HBsAg or a student who is considered a non-responder to Hep B immunization* ❑Letter attached

Health Care Provider Name | Health Care Provider Signature | Date | Clinic Stamp: