

STUDENT IMMUNIZATION CLEARANCE FORM

Program <input type="checkbox"/> BScN <input type="checkbox"/> Practical Nurse <input type="checkbox"/> Health Care Aide
Student 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	<ul style="list-style-type: none"> ○ 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) <i>*the last dose must be within the last 10 years*</i>
PERTUSSIS	<ul style="list-style-type: none"> ○ 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	<ul style="list-style-type: none"> ○ 2 doses of varicella-containing vaccine after 12 months 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. <p>Serology after vaccination is not recommended.</p>	<p><u>Varicella:</u></p> Dose #1: _____ Dose #2: _____ OR Varicella Serology: RESULTS MUST BE ATTACHED Date: _____ Result: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> N/A

VACCINE	REQUIREMENTS	RESULTS
MEASLES, MUMPS & RUBELLA	<ul style="list-style-type: none"> ○ 2 valid doses of measles-containing vaccine after 12 months of age ○ 2 valid doses of mumps-containing vaccine after 12 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 	<p>Measles: Dose #1: _____ Dose #2: _____</p> <p>Mumps: Dose #1: _____ Dose #2: _____ _____</p> <p>Rubella: Dose #1 _____ Additional Doses: _____</p>
TUBERCULOSIS TESTING	<ul style="list-style-type: none"> ○ 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. <p>REPORT MUST BE ATTACHED</p>	<p>Date of TST: _____</p> <p>Date of Reading: _____ Result: _____ mm</p> <p>If required:</p> <p>Chest X-Ray Date: _____</p> <p>Result:</p> <p><input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> N/A</p> <p>Referral to TB Services? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
COVID 19	<ul style="list-style-type: none"> ○ Series of 2 doses of vaccines below. ○ Moderna , Pfizer-BioNTech, and AstricaZeneca/COVISHIELD are 2 dose vaccines. <p>Please provide documentation of your covid vaccine</p>	<p>Vaccine Name</p> <p><input type="checkbox"/> Dose One of Two Date _____</p> <p><input type="checkbox"/> Dose Two of Two Date _____</p> <p><input type="checkbox"/> Not Immunized – Documentation required.</p>

VACCINE	REQUIREMENTS	RESULTS
HEPATITIS B	<ul style="list-style-type: none"> ○ 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 	<p>Hepatitis B Vaccination:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>Additional Doses:</p> <p>3. _____</p> <p>5. _____</p> <p>6. _____</p>
HEPATITIS B BLOOD TESTING	<ul style="list-style-type: none"> ○ 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 <p>Not at risk of past infection: an Anti-HBs serology is required</p> <p>At risk of past infection: an Anti-HBs, Anti-HBc & HBsAg are required.</p> <ul style="list-style-type: none"> ○ 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 <i>not at risk of past infection</i>) and a letter 	<p><input type="checkbox"/> Student is NOT AT RISK of past infection OR <input type="checkbox"/> Student is AT HIGH-RISK of past infection - <i>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.</i></p> <p>Mandatory Serology: <i>Required for all students</i></p> <p>Anti-HBs: RESULTS MUST BE ATTACHED Date: _____ Result: _____ U/L Interpretation: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE</p> <p>If required:</p> <p>Anti-HBc: RESULTS MUST BE ATTACHED <i>Required for those students at high-risk of past Hep B infection</i> Date: _____ Result: _____ <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> N/A</p> <p>HBsAg: RESULTS MUST BE ATTACHED <i>Required for those students at high-risk of past Hep B infection or those considered non-responders to Hep B immunization</i> Date: _____ Result: _____ <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> N/A</p>

	<p>from a physician should be provided explaining the students' Hep B status.</p> <ul style="list-style-type: none"> ○ 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 <i>not at risk of past infection</i>) and a letter from a physician should be provided explaining the students' Hep B status 	<p>Letter from physician explaining results: <i>Required for students who have a positive Anti-HBc, a positive HBsAg or a student who is considered a nonresponder to Hep B immunization</i></p> <p><input type="checkbox"/> Letter attached</p>
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Clinic Stamp:

 Health Care Provider Name

 Health Care Provider Signature

 Date