Confederation College Health Center

P: 807-475-6169 F: 807-473-3706

HealthCentre@confederationcollege.ca

**Communicable Disease Surveillance (CDS) Form**

The college has immunization/testing requirements for all students doing clinical/community placement practice in designated agencies. Students applying for entry into the programs listed below require current immunization verification**. Completed forms must dropped off prior to the start of your program to Confederation College Health Centre or to your Regional Campus/Distance Ed department.**

**Section A: Personal Information**

|  |  |
| --- | --- |
| **First Name:** | **Last Name:** |
| **Date of Birth: (DD-MM-YYYY)**   | **Email:** |
| **Address:** | **City:**  |
| **Province:** | **Postal Code:** | **Telephone/Cell:** |

**Section B: Programs & Requirements** (Circle the appropriate box for the program you are registered in).

|  |  |
| --- | --- |
|  **HEALTH SCIENCES** | **Below are the requirements for each program** |
| **Dental Assisting** | **Dental Hygiene** | **Serology (bloodwork)****2 Step TB Skin Test****Hepatitis B****Varicella****Measles, Mumps, Rubella****Tetanus** |
| **Medical Laboratory Assistant** | **Medical Radiation Technology** |
| **Paramedic** | **Personal Support Worker** |
| **Practical Nursing** |  |

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| **COMMUNITY SERVICES** | **Below are the requirements for each program** |
| **Autism & Behavioural Science** | **Child & Youth Care** | **Serology (bloodwork)****2 Step TB Skin Test****Varicella****Measles, Mumps, Rubella** **Tetanus**  |
| **Developmental Services Worker** | **Child & Youth Care- Acc** |
| **Developmental Services Worker -Acc** | **Early Childhood Education** |
| **Educational Support** | **Onajigawin Indigenous Services** |
| **Recreation Therapy** | **Onajigawin Indigenous Services -Acc** |
| **Recreation Therapy-Acc** | **Social Service Worker** |
| **Aboriginal Advocacy** | **Social Service Worker Acc** |

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| *Failure to provide current immunization documentation and proof of recent tuberculin skin testing as outlined for your program can affect your eligibility to attend the clinical or community placement components of your program. Confederation College maintains compliance with all privacy requirement; including the Freedom of Information and Protection of Privacy Act (FIPPA), the Personal Information Protection and Electronic Documents Act (PIPEDA), and the Personal Health Information Privacy Act (PHIPA). The Privacy Commissioner of Ontario can be reached at 1800- 387-0037.****Authorization for disclosure:*** *The information on this form will be kept confidential within the Health Centre. However, I authorize the release of information concerning my status in regards to completion of current immunization and tuberculin skin testing to my faculty advisor and coordinator, and/or Regional Director* |
| ***Student Full Name(print):*** | ***Student Signature(mandatory):*** |

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**Section C: IMMUNIZATIONS**

**C.1 Tuberculosis** (Student must receive an initial 2-Step TB Skin test, and then an annual 1-Step. (To be read **within 48 hrs**).

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| --- | --- | --- | --- | --- |
|  | **TB Skin Test** | **Date read** | **Induration (mm)** | **HealthCare Provider’s Signature** |
| STEP #1 |  |  |  |  |
| STEP #2 |  |  |  |  |
| Annual |  |  |  |  |
| Annual |  |  |  |  |
| **Chest X-Ray** | Date | Results |

**C.2 Hepatitis B** (If non-immune, a booster may be required).

|  |  |  |
| --- | --- | --- |
| **Immunization** | **Date of serology** | **RESULTS** |
| Hepatitis B Titre |  | Reactive  | Non-Reactive |

|  |  |
| --- | --- |
| **Immunization** | **DATE GIVEN** |
| Hepatitis B Dose #1 |  |
| Hepatitis B Dose #2 |  |
| Hepatitis B Dose #3  |  |
| **Hepatitis Booster** |  |

**C.3 Measles, Mumps, Rubella** (Booster dose to be administered if inadequate).

|  |  |  |
| --- | --- | --- |
| **Immunization** | **Date of serology** | **RESULTS** |
| Measles Titre |  | Reactive | Non-Reactive | Indeterminate |
| Mumps Titre |  |  Reactive | Non-Reactive | Indeterminate |
| Rubella Titre |  |  Reactive | Non-Reactive | Indeterminate |

|  |  |
| --- | --- |
| **Immunization** | **DATE GIVEN** |
| MMR Dose #1 |  |
| MMR Dose #2 |  |
| **MMR Booster** (if needed) Date |  |

**C.4** **Varicella** (2nd dose must be administered at least 4 weeks after 1st dose, if inadequate immunity).

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| --- | --- | --- |
| **Immunization** |  **Date of serology** | **RESULTS** |
| Varicella Titre |  | Reactive | Non-Reactive | Indeterminate |

|  |  |
| --- | --- |
| **Immunization** | **DATE GIVEN** |
| Varicella Dose #1 |  |
| Varicella Dose #2 |  |

**C.5 Tetanus, Diphtheria** (Due every 10 years).

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| --- | --- |
| **Immunization** | **DATE GIVEN** |
| Tetanus, Diphtheria, Pertussis (Tdap) |  |

**C.6 Influenza Vaccine**

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| --- | --- |
| **Vaccinations** | **DATES GIVEN** |
| Influenza Vaccine |  |  |  |

**C.7 COVID Vaccine**

|  |  |  |
| --- | --- | --- |
| **Vaccinations** | **DATE GIVEN** | **TYPE** |
| COVID Dose #1 |  |  |
| COVID Dose #2 |  |  |
| COVID Dose #3 |  |  |

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