



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

**THE FOLLOWING PROGRAMS MUST COMPLETE THIS FORM**

(Early Childhood Education, Food and Nutrition Administration/Management, Social Service Worker, Indigenous Wellness and Addiction Prevention)

**COMMUNICABLE DISEASE SCREENING PROTOCOL**

Please document all dates as day/month/year and complete all 3 pages of this form

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

**Permanent Address:**

|                 |               |                      |                    |
|-----------------|---------------|----------------------|--------------------|
| _____<br>Street | _____<br>City | _____<br>Postal Code | _____<br>Telephone |
|-----------------|---------------|----------------------|--------------------|

**Address While Attending School:**

|                 |               |                      |                    |
|-----------------|---------------|----------------------|--------------------|
| _____<br>Street | _____<br>City | _____<br>Postal Code | _____<br>Telephone |
|-----------------|---------------|----------------------|--------------------|

**Person to Contact in Case of Emergency:**

|               |                    |
|---------------|--------------------|
| _____<br>Name | _____<br>Telephone |
|---------------|--------------------|

**Family Physician:**

|               |                    |
|---------------|--------------------|
| _____<br>Name | _____<br>Telephone |
|---------------|--------------------|

**I authorize the Health Centre to release my clearance status for placement purposes to my program coordinator.**

|                            |               |
|----------------------------|---------------|
| _____<br>Student Signature | _____<br>Date |
|----------------------------|---------------|

**SECTION BELOW FOR ADMINISTRATIVE PURPOSES ONLY**

|   |   |   |   |
|---|---|---|---|
| Communicable Disease<br><b>Year 1 Clearance</b> | Communicable Disease<br><b>Year 2 Clearance</b> | Communicable Disease<br><b>Year 3 Clearance</b> | Communicable Disease<br><b>Year 4 Clearance</b> |
| _____<br>Date                                   | _____<br>Date                                   | _____<br>Date                                   | _____<br>Date                                   |

**FLU VACCINE DOCUMENTATION MAY BE REQUIRED IN MANY CLINICAL SETTINGS:**

|                                      |                                      |                                      |                                      |
|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
| Influenza<br><b>Year 1 Clearance</b> | Influenza<br><b>Year 2 Clearance</b> | Influenza<br><b>Year 3 Clearance</b> | Influenza<br><b>Year 4 Clearance</b> |
| _____<br>Date                        | _____<br>Date                        | _____<br>Date                        | _____<br>Date                        |

Please select one of the following options for TB screening and SIGN either Option #1 or Option #2 on this page  
 Reminder – BCG is not a contraindication for TB skin testing. \*5mm or more is considered positive for those infected with HIV, those who are recent close contacts of a patient with active TB and those who have chest x-ray findings consistent with healed TB.  
 10mm or more is considered positive for all others.

| Disease                                 | Required   | Attn: Health Care Providers<br>DO NOT sign until requirements are met |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
|---|--|---|-----------|---------------------------------|-----------|-------------------------|--|-------------------|----|----------|----|--|----|----------------------------|---------------|---|--------------|--|--------------|--|--------------|--|--------------|--|--|--|--|--|--|
| Tuberculosis                            | <p><b>Option #1</b><br/> <b>Known history of Positive TB Skin Test.</b><br/>           Chest x-rays should be taken on individuals who have:</p> <ol style="list-style-type: none"> <li>never been evaluated for a positive Mantoux skin test or for TB;</li> <li>had a previous diagnosis of TB but has never received adequate treatment for TB or;</li> <li>Pulmonary symptoms that may be due to TB</li> </ol> <table border="1" data-bbox="321 604 1105 947"> <thead> <tr> <th colspan="2">Date</th> </tr> </thead> <tbody> <tr> <td><b>Positive Skin Test Date:</b></td> <td></td> </tr> <tr> <td><b>Last Chest X-ray</b></td> <td></td> </tr> <tr> <td><b>Sputum x 3</b></td> <td>1.</td> </tr> <tr> <td></td> <td>2.</td> </tr> <tr> <td></td> <td>3.</td> </tr> <tr> <td colspan="2"><b>Treatment Received:</b></td> </tr> <tr> <td><b>Current/Annual Symptom Screening</b></td> <td><b>Date:</b></td> </tr> <tr> <td></td> <td><b>Date:</b></td> </tr> <tr> <td></td> <td><b>Date:</b></td> </tr> <tr> <td></td> <td><b>Date:</b></td> </tr> </tbody> </table> | Date  |           | <b>Positive Skin Test Date:</b> |           | <b>Last Chest X-ray</b> |  | <b>Sputum x 3</b> | 1. |          | 2. |  | 3. | <b>Treatment Received:</b> |               | <b>Current/Annual Symptom Screening</b> | <b>Date:</b> |  | <b>Date:</b> |  | <b>Date:</b> |  | <b>Date:</b> | <hr/> Print Name<br><hr/> Signature<br><hr/> <hr/> <hr/> <hr/> |  |  |  |  |  |
| Date                                    |  |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
| <b>Positive Skin Test Date:</b>         |  |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
| <b>Last Chest X-ray</b>                 |  |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
| <b>Sputum x 3</b>                       | 1.   |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
|   | 2.   |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
|   | 3.   |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
| <b>Treatment Received:</b>              |  |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
| <b>Current/Annual Symptom Screening</b> | <b>Date:</b>   |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
|   | <b>Date:</b>   |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
|   | <b>Date:</b>   |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
|   | <b>Date:</b>   |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
| Tuberculosis                            | <p><b>Option #2</b><br/> <b>2 step TB skin testing is required. Provide documentation of previous two-step TB skin test, if not available, do current 2 step TB skin test. If completed more than 12 months ago, do and document single TB skin test below.</b></p> <table border="1" data-bbox="321 1203 1105 1291"> <thead> <tr> <th></th> <th>Date</th> <th>MM induration</th> <th>Date Read</th> </tr> </thead> <tbody> <tr> <td>Step One</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Step Two</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>(Step two given within 1 to 3 weeks of Step 1)</p> <p><b>INTERPRETATION</b> (Positive/Negative): _____</p> <p>Current/Annual Skin Test is required.</p> <table border="1" data-bbox="321 1438 1105 1612"> <thead> <tr> <th>TB Skin Test Date</th> <th>MM induration</th> <th>Date Read</th> </tr> </thead> <tbody> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </tbody> </table>          |   | Date      | MM induration                   | Date Read | Step One                |  |                   |    | Step Two |    |  |    | TB Skin Test Date          | MM induration | Date Read                               |              |  |              |  |              |  |              |  |  |  |  |  | <hr/> Print Name<br><hr/> Signature<br><hr/> <hr/> <hr/> <hr/> |
|   | Date   | MM induration   | Date Read |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
| Step One                                |  |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
| Step Two                                |  |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
| TB Skin Test Date                       | MM induration  | Date Read   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
|   |  |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
|   |  |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
|   |  |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
|   |  |   |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |
| Tetanus<br>Diphtheria<br>Polio          | <p>Td is recommended every 10 years. A Polio booster should also be considered (TdP) due to uncertainty of clinical placement/travel.</p> <p>Td Date: _____ AND/OR Adacel Date: _____</p> <p>Vaccine Name: _____</p>   | <hr/> Print Name<br><hr/> Signature<br>                               |           |                                 |           |                         |  |                   |    |          |    |  |    |                            |               |   |              |  |              |  |              |  |              |  |  |  |  |  |  |

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

| Disease                          | Required  | Attn: Health Care Providers<br>DO NOT sign until<br>requirements are met |
|----------------------------------|---|--|
| <b>MMR<br/>Immune<br/>Status</b> | <p><b>1<sup>st</sup> dose of MMR on or after first birthday:</b><br/>Vaccine Name: _____ Date: _____</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2<sup>nd</sup> dose of MMR:</b><br/>Vaccine Name: _____ Date: _____</p> <p style="text-align: center;"><b>OR</b></p> <p><b>Blood Test for Measles Antibody:</b><br/>Result: _____ Date: _____</p> <p>If results "non-immune", give MMR Vaccine<br/>Vaccine Name: _____ Date: _____</p> <p><b>Blood Test for Mumps Antibody:</b><br/>Result: _____ Date: _____</p> <p>If result "non-immune", give MMR Vaccine<br/>Vaccine Name: _____ Date: _____</p> <p><b>Blood Test for Rubella Antibody:</b><br/>Result: _____ Date: _____</p> <p>If result "non-immune", give MMR Vaccine<br/>Vaccine Name: _____ Date: _____</p> | <p>_____</p> <p>Print Name</p> <p>_____</p> <p>Signature</p>             |
| <b>Varicella</b>                 | <p><b>History of Chicken Pox or Shingles.</b> Date: _____</p> <p style="text-align: center;"><b>OR</b></p> <p><b>Blood test for Varicella Antibody:</b><br/>Result: _____ Date: _____</p> <p style="text-align: center;"><b>AND/OR</b></p> <p>If negative history of disease and/or negative titre, two doses of<br/>Varicella Vaccine are required (vaccine cost to be paid by the<br/>student)</p> <p>Dose 1 Date: _____</p> <p>Dose 2 Date: _____</p>  | <p>_____</p> <p>Print Name</p> <p>_____</p> <p>Signature</p>             |