

Immunization Verification Form for Holland College Healthcare Programs

{To be considered current, this form must be completed within 12 months prior to the start date of the Program.}

Student Name: _____ Student ID _____

Phone No: _____ Month/Year _____

Address: _____ of Birth: _____ / _____

Send this completed form to Holland College Admissions Office prior to the program start-date. To be considered current, this form must be completed within 12 months prior to the start date of the Program.

The guidelines for immunization of adults who will be working in health care settings in Canada have been derived from the Canadian Immunization Guide and, in collaboration with, clinical and practicum partners (Canadian Immunization Guide - Canada.ca). The immunization requirements described on this form were accurate at time you obtained the form from Holland College. The College has no control over requirements established by clinical and practicum placement sites. Requirements may be changed at the discretion of the worksite and the worksite has the right to deem any record as not acceptable. If more information is needed, the program Clinical / Practicum Coordinator will contact you. If you have any questions, call the Health Studies Department at 1.902.566.9672.

This form is to be completed by a nurse practitioner, physician, or public health official following an examination of the immunization records of the above applicant. The nurse practitioner, physician, or public health official that administered your immunization as a child and during your school years can complete this form. If your records are not available, you will have to be screened and or immunized again.

If you are **accepted** into a program that requires immunization, you can book your immunizations and testing through the Holland College Health Clinic. To book an appointment, please email npclinic@hollandcollege.com or call 902-566-9392. You will need your health card and your vaccination record.

Rationale: Health care workers, including students in health care disciplines, who participate in work term, clinical and/or practicum experiences in hospitals, laboratories, and long-term, primary, home, community, and emergency health care agencies, vehicles, and/or worksites are at risk of exposure to communicable diseases because of their contact with patients or material from individuals with infections, both diagnosed and undiagnosed. Immunization directly protects vaccine recipients and indirectly protects vulnerable individuals who may not respond to vaccines or for whom vaccines may be contraindicated.

Students accepted in health care programs are required to have up-to-date immunizations and TB testing to be permitted to participate in clinical practice settings. There is up to a 6-month waiting time between some doses of immunizations. To ensure that you will meet all the requirements before or soon-after your program start-date, it is recommended that you begin the process **as-soon-as-possible after your acceptance into the program**. You can begin the program if the immunization and testing process has started with a plan in place for completion. Students accepted to a health program will not be allowed into clinical or practicum settings without the required immunizations and testing and therefore will not be able to complete the program.

Surname:		Given Name:	
DOB: (Day/Month/Year)	Phone Number:	Email address:	
Provincial Health Card #	Country/Province:		

Immunizations & Titre Requirements (Please attach a copy of the results)					Meets Requirements
DTP (Diphtheria/Tetanus/Pertussis/Polio) Primary Series (Initial 4 doses)	Date of 1st dose:	Date of 2nd dose:	Date of 3rd dose:	Date of 4th dose:	<input type="checkbox"/>
dTap Booster (Must have receive within the last 10 years)	Date of Booster:				<input type="checkbox"/>
MMR (Measles/Mumps/Rubella) If no vaccines received titres for MMR required	Date of 1st dose:		Date of 2nd dose:		<input type="checkbox"/>
Measles Titre (if not immunized with 2 doses of MMR vaccine)	Draw Date: Attach Documentation		Results:		<input type="checkbox"/>
Rubella Titre (if not immunized with 2 doses of MMR vaccine)	Draw Date: Attach Documentation		Results:		<input type="checkbox"/>
Mumps Titre (if not immunized with 2 doses of MMR vaccine)	Draw Date: Attach Documentation		Results:		<input type="checkbox"/>
Varicella (Chicken Pox)	Date of 1st dose:		Date of 2nd dose:		<input type="checkbox"/>
Varicella Titre (if history of disease or no record of immunization)	Draw Date: Attach Documentation		Results:		<input type="checkbox"/>
Hepatitis B (3 dose requirement)	Date of 1st dose:	Date of 2nd dose:	Date of 3rd dose:	Date of Booster(s):	<input type="checkbox"/>
Hepatitis B Titre (post-immunization serologic testing required)	Draw Date: Attach Documentation		Results:		<input type="checkbox"/>
Influenza Immunization (Recommended yearly)	Date of last influenza vaccine:				<input type="checkbox"/>
COVID-19 Immunization (Mandatory record of most recently recommended primary series)	Dates Primary series (Required):		Additional vaccine dates (Recommended):		<input type="checkbox"/>

Two Step Tuberculosis (TB) Test (Mantoux)				
Step One	Date Given: _____ Date Read: _____	Results: _____ mm	Chest X-Ray: Yes ___ No ___ Results (attached):	<input type="checkbox"/>
Step Two	Date Given: _____ Date Read: _____	Results: _____ mm	IGRA (Y/N) attached:	
TB skin test (within last 12 mths)	Date Given: _____ Date Read: _____	Results: _____ mm	BCG vaccine: Yes ___ No ___	

Nurse Practitioner, Physician or Public Health official declaration:

After an examination of the immunization records of the individual named above, it is my opinion that the "student" meets the guidelines listed above.

Please do not sign until all requirements are met.

Signature (Nurse
Practitioner/Physician/
Public Health): _____

Date: _____

Nurse Practitioner/Physician/Public Health Contact Information: (Please Print)

Name: _____ Business Phone No: _____

Clinic/Office Business Address: _____

The personal information requested on this form is collected under the authority of Section 31(c) of the PEI Freedom of Information and Protection of Privacy Act and will be protected under Part 2 of that Act. It will be used to verify the immunization of applicants to the Health programs at Holland College. If you have any questions about the collection or use of this information, please contact the Chief Privacy Officer at privacy@hollandcollege.com or 902-566-9542, 140 Weymouth St., Charlottetown, PE, C1A 4Z1.

* Public Health Agency of Canada (www.publichealth.gc.ca)

* Canadian Immunization Guide (<http://www.phac-aspc.gc.ca/publicat/cig-gci/index-eng.php>)