Occupational Health & Safety

Thunder Bay Regional Health Sciences Centre
980 Oliver Rd.,
Thunder Bay, ON P7B 6V4
Phone (807) 684-6240
Fax (807) 684-5832

Entry Immunization Form

PRE PLACEMENT REQUIREMENTS FOR OBSERVERS, LEARNERS, CO-OP STUDENTS, VOLUNTEERS AND SECURITY CARRYING ON ACTIVITIES IN THE HEALTH CARE CENTRE

Persons applying for placement within the Hospital have an obligation to protect patients and themselves from infection that can be transmitted within clinical or other placement settings. Immunization is an important tool in preventing the transmission of infections.

The Communicable Disease Surveillance Protocols for Ontario Hospitals, developed by the Ontario Hospital Association and the Ontario Medical Association, in accordance with Regulation 965/90 Section 4 of the Public Hospital's Act, applies to **all** persons carrying on activities in the Health Care Centre including but not limited to employees, physicians, nurses, contract workers, students, post-graduate medical trainees, researchers and volunteers.

This document outlines the **immunization status and tuberculosis testing verification required.**

The completion of this form is mandatory, prior to you starting at Thunder Bay Regional Health Sciences Centre. Failure to submit a signed and correctly completed immunization form may result in being withheld from hospital work.

Computerized records of childhood vaccines can be obtained by calling the Thunder Bay District Health Unit or your local Public Health Department. Contact information for all Ontario Public Health Departments can be found on the following website:
http://www.health.gov.on.ca/english/public/contact/phu/phuloc_mn.html

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A. PERSONAL INFORMATION

Last Name:		First Name:	
Date of birth: | _ _ | _ _ | _ _ _ _| Day / Mo / Year	**Volunteers & Security only**: OHIP #:		
Address:		Apt.#:	**FOR OFFICE USE ONLY** Date Accepted as Complete | _ _ | _ _ | _ _ _ _ | Day/ Mo/ Year ☐Volunteer ☐Security
City:	Province:	Postal Code:	
Local Tel. # Cell#: Email :			

B. IMMUNIZATION STATUS

B.1

Tetanus/Diphtheria (Due every 10 years) Date of last immunization ______________________________

Pertussis Date of last immunization ______________________________

Polio Date of last immunization ______________________________

B.2

Varicella (Chicken Pox): Varicella antibody serology (bloodwork) is required if there is no proof of two Varicella vaccines.

Varicella vaccination:

1st vaccination: Date: _________________________ 2nd vaccination: Date : _____________________

Laboratory evidence of immunity: Results ______________________ **Date:** _____________________

B.3

MMR (Measles Mumps, Rubella): MMR antibody serology (bloodwork) is required if there is no documented proof of two MMR vaccines.

Immunization Dates:
Initial vaccination dates: 1st : ________________________ 2nd: _____________________________

Possible additional booster date: _____________________

Laboratory evidence of immunity: Measles:_____________ **Mumps:**_____________ **Rubella:**_____________

B. 4

Hepatitis B: The process of three injections must have begun prior to placement

1st vaccination: Date: _____________________________

2nd vaccination: Date: _____________________________

3rd vaccination: Date: _____________________________

Laboratory evidence of immunity: Results:____________ **Date:**_____________________________

B.5

TB skin testing (Mantoux):

One documented Two-Step TB skin test is required for all persons carrying on activities within TBRHSC.

Test #1 given on (date): _______________ Result (mm of induration): ____________

Test #2 given on (date): _______________ Result (mm of induration): ____________

A One-Step TB skin test is required if the last test is greater than twelve months ago.

Test #1 given on (date): _______________ Result (mm of induration): ____________

Prior history of BCG vaccination: ☐ No ☐ Yes: Year ___________________
Prior history of TB infection: ☐ No ☐ Yes: Year ___________________
Treatment : ☐ No ☐ Yes
HISTORY: Documentation of previous 2 step TB skin test:

A chest X-ray is required if you have EVER had a documented positive TB skin test.

☐ **Chest X-Ray Report Enclosed**

For the use of Occupational Health and Safety only:

Test #1 given on (date): _______________ Result (mm of induration): _____________ Initial:_______

Test #2 given on (date): _______________ Result (mm of induration): _____________ Initial:_______

SIGNATURE (Nurse)	**Full Name: (print)**	**Signature**	**Date**

B.6

Meningococcal A,C,Y,W-135 vaccine Date of vaccine: ________________________________

This immunization is strongly recommended for Medical Lab Technologists, Respiratory Therapists and other high risk areas. This is not a mandatory immunization.

B.7

Influenza (flu) vaccine: Vaccination date: _______________________.

In the event of an outbreak in the hospital in which the students are placed, non-immunized students may be prohibited from continuing their placement, thus jeopardizing successful completion of their placement.

C. FIT TESTING

Fit testing is recommended for anyone who has a job function that would require them to wear an N95 mask. The N95 mask is currently worn as a basic mask for respiratory isolation and routine respiratory precautions in ER, ICU, and for entering the room of a suspect or confirmed TB patient.

Does this apply to your role within TBRHSC? Yes ( ) No ( )
Have you been fit tested within the last two years as per CSA Standard Z94, 4-02? Yes ( ) No ( )

If yes indicate type of mask:
Date: _____________________ Mask Type: _________________________

D. SIGNATURE (Mandatory)	**Full Name**: (print)	**Signature**	**Date**

References: Public Hospitals Act, Regulation 965/90, Section 4; Communicable Disease Surveillance Protocols 2016