CLINICAL/FIELDWORK PLACEMENT REQUIREMENTS FOR SCHOOL OF REHABILITATION THERAPY

2023 - 2024

Proof of Immunization/Serologic Status

Confidential

Requirements	Full Immunization Record	Mantoux Test (TB)	Flu Shot	First Aid- CPR	Criminal Record Check
Year 1 September, 2023	✓	✓	✓	✓	✓
Year 2 September, 2024		✓	✓	✓ (BLS must be recertified every year)	✓

Please keep the originals and a copy of your documents

Submit a copy of all documents to the School

Immune Status Consent Form

School of Rehabilitation Therapy, Queen's University

Please read this document carefully, and be sure you understand it completely before signing below.

For purposes of this document, 'immune status' refers to the immunizations and/or testing that is required of students as per the policies of the School of Rehabilitation Therapy, Queen's University. This includes immunizations and/or testing related to diphtheria, hepatitis B, influenza, measles, mumps, rubella, pertussis, polio, tetanus, tuberculosis, and varicella (chicken-pox). Other agents of disease may be included as outlined in (3) below.

1. I understand that maintaining an accurate and up-to-date immune status record is an important responsibility of being a student, to protect my own health, as well as the health of the patients with whose care I will be involved.

2. While I understand that in general immunizations and health screening tests are voluntary procedures, I acknowledge that the procedures within the scope of this document are also a condition of enrolment within my chosen program of study. At any time, I may refuse any part of the proposed immunizations or testing and I understand that this may mean I may not be allowed to participate in clinical activities involving patients.

3. I understand that on occasion immune status recommendations or requirements may change based on new information and evidence, outbreaks of communicable diseases, or university policies. I accept that it is my responsibility to follow through on immune status recommendations or requirements of the facility while I am enrolled as a student.

4. I understand that my immune status personal health information will only be used by those directly involved with the School of Rehabilitation Therapy and only for the stated purposes of the program; this may include certain designated individuals directly involved with immunization screening and those coordinating clinical placements.

5. I agree that if required, the School of Rehabilitation Therapy may obtain and use from an external source, records of immunizations, testing, or treatment of infectious diseases that fall within the scope of this document. An external source includes but is not limited to my family physician, public health, specialty care, healthcare institutions, laboratories, and immunization registries.

6. I give permission for all or part of my immune status record to be disclosed to the occupational health departments of the facilities in which I will conduct my clinical placements, at the discretion of the School of Rehabilitation Therapy, so long as I remain a student within the facility.

7. If additional testing for or treatment of a communicable disease within the scope of this document is conducted by occupational health or infection control of a healthcare institution, or by public health or another institution in the community, I agree that this information may be received and used by the School of Rehabilitation Therapy, so long as I remain a student within the faculty.

8. I understand that I must maintain all original copies of my immune status record, for as long as I am a student in the School of Rehabilitation Therapy.

9. I understand that my immune status record will be kept secure while I am a student within the School of Rehabilitation Therapy, and I may request the document at the time of graduation, after which time the Immune Status Program will opt to destroy my immune status record in a secure and confidential manner, consistent with accepted methods of disposal of health records.

_____ _____

Student Signature Date

_____

Student Name (please print)

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Student Name	Program

Please refer to the attached policy for clarification on specific sections of this form.

TUBERCULOSIS **Tuberculin Skin test (TST) done within the last 12 months**

Option #1: 2 step Tuberculin Skin Test (TST) Documentation Required

	Date	mm in duration	Healthcare Professional Signature
Step 1			
Step 2			

Option #2: If a 2-step test was completed at least once in a lifetime, but more than 12 months ago, record these results above **AND** provide documentation of a single step TST.

	Date	mm in duration	Healthcare Professional Signature
Step 1			

ANNOTATIONS

- Two steps should be 1-3 weeks apart
- 10mm or more induration is positive (or 5 mm or more for those infected with HIV, or in recent close contact with active Tb or with chest x-ray indicating healed TB)
- Results must be recorded as millimetres of induration (NOT “positive” or “negative”)
- If either TST is positive this must be reported to the School and a chest x-ray report is required.
- Students with a positive test and a clear x-ray will not need another x-ray for 3 years unless symptomatic or exposed

Student Name:_____

TETANUS/DIPTHERIA/PERTUSSIS

Dose	Date	Healthcare Professional Signature
Primary Series (DPT) completed		
TDAP booster (Adacel)		
TD 10 year booster last completed		

ANNOTATIONS

- Students must provide proof of receipt of primary series of DPT vaccines **as well as a booster containing acellular pertussis vaccine (usually given in adolescence).**
- If primary series or booster was completed 10 or more years ago and the booster contained acellular pertussis, a TD booster is required.
- If there is no proof of primary series, one TDAP and two TD are required (the second at 2 months and the third at 6-12 months)
- Students are responsible for ensuring that these boosters remain up to date after admittance to the School of Rehabilitation Therapy.

VARICELLA

Titre	Date	Healthcare Professional Signature
☐ Reactive/Immune (+) ☐ Non-reactive (non-immune) (-)		

or

Dose	Date	Healthcare Professional Signature
Dose 1		
Dose 2		

ANNOTATIONS

- A history of disease alone is not sufficient evidence of immunity to varicella unless accompanied by laboratory confirmation.
- If non-reactive/non immune, immunization is required with documentation submitted to the School.
- Non-immune students who have a contraindication to receiving the varicella vaccine must inform the School upon registration and will be referred for advice.

Student Name:_____

MEASLES, MUMPS, RUBELLA (MMR)

Measles Titre	Date	Healthcare Professional Signature
□ Reactive/Immune (+) □ Non-reactive (non-immune) (-)		

Mumps Titre	Date	Healthcare Professional Signature
□ Reactive/Immune (+) □ Non-reactive (non-immune) (-)		

Rubella Titre	Date	Healthcare Professional Signature
□ Reactive/Immune (+) □ Non-reactive (non-immune) (-)		

or

MMR Dose	Date	Healthcare Professional Signature
Dose 1		
Dose 2		

ANNOTATIONS:

- If non-reactive/non immune, immunization is required with documentation submitted to the School.
  or
- Students must provide evidence of **two** doses of measles, mumps, rubella (MMR) vaccine.

POLIO

Polio Series	Date	Healthcare Professional Signature
Dose 1		
Dose 2		
Dose 3		
Dose 4		
Dose 5		

ANNOTATIONS

- Students are required to provide documentation of a complete series of polio vaccine.
- Polio vaccine series consists of 5 doses for children up to 6 years old and 3 doses if primary series started after age 7 (adult dose). Four doses are sufficient if one was given after age 4.

Student Name:_____

HEPATITIS B All of section A must be completed

SECTION A		
Hep B Series (2 doses if completed in grade 7)	**Date**	**Healthcare Professional Signature**
Dose 1		
Dose 2 (1 month following dose #1)		
Dose 3 (6 months following dose #1)		
Complete titre to determine surface antibody level (Anti-HBs) ☐ Reactive/Immune (+) ☐ Non-reactive/non-immune (-)		
If Non-reactive: HBsAg is **positive:** ☐ or **negative:** ☐		

SECTION B		
If non-immune give	**Date**	**Healthcare Professional Signature**
Dose 4		
Complete titre to determine surface antibody level (Anti-HBs) ☐ Reactive/Immune (+) ☐ Non-reactive/non-immune (-)		
If non-immune complete second series Dose 5		
Dose 6		
Complete titre to determine surface antibody level (Anti-HBs) ☐ Reactive/Immune (+) ☐ Non-reactive/non-immune (-)		

ANNOTATIONS

- If a student is non-reactive, but there is record of past immunization, the student will receive a booster and must have a repeat titre 1 month following the receipt of the booster.
- Students who continue to be non-immune after a booster must complete the second series and have a repeat titre.
- If the result of any HBsAg test is positive, the student will be referred for counselling by the Director of the School. They will also need HBeAg, anti-HBe and hepatitis B DNA levels.

COVID-19

Dose	Date	Healthcare Professional Signature
Dose 1		
Dose 2		
Booster		

ANNOTATIONS

- Two shots are required at this time. Enter a booster if applicable.