TRENT/FLEMING SCHOOL OF NURSING
1600 West Bank Drive, Peterborough, ON Canada K9L 0G2
705 -748-1099, nursing@trentu.ca

Trent Fleming School of Nursing Immunization and Communicable Disease Form

Student's Given Name:

Student's Previous/Preferred Name (if applicable):

Student ID#:

Trent email:

Phone Number:

Note to Healthcare Providers

Thank you for your cooperation with the immunization process for candidates admitted to the Trent/Fleming School of Nursing. The Non-Academic Requirements for BScN students have been developed to reflect the immunization and screening requirements of the various agencies where the students may attend clinical practice. Failure to complete the form and provide documentation of the required serology results will prevent the student from attending clinical and may result in deregistration from the BScN program. Please note all information must be transcribed onto this form, as supporting documents alone will not be accepted.

Healthcare provider professional stamp (or name and address of clinic where the form was completed:

Date:

HCP Signature:

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Part 1: Red Measles, Mumps, Rubella (German Measles)-MMR

Serology results for MMR must be completed. Results must be documented below, and **copies of the blood work results must be submitted.**

If Serology results indicate Non-Immune or Indeterminate, documentation of two vaccinations of MMR is required and one of these vaccinations must be a booster dose (vaccination given post blood work results).

Healthcare providers please fill out the dates and indicate immune or non-immune. Please attach a copy of the blood work results.

Communicable Disease Information:

Measles

Date of Serology Results (mm/dd/yyyy):
Immune or Non-immune:
HCP Initials:

Mumps

Date of Serology Results (mm/dd/yyyy):
Immune or Non-immune:

HCP Initials:

Rubella

Date of Serology Results (mm/dd/yyyy):
Immune or Non-immune:

HCP Initials:

Please provide two (2) vaccination dates below if blood work results were non-immune or indeterminate. One of these vaccinations must be a booster dose (vaccination given post blood work).

MMR Vaccination Dates:

1st Vaccination Date (mm/dd/yyyy):

HCP Initials:

2nd Vaccination Date (mm/dd/yyyy):

HCP Initials:

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Part 2: COVID-19 Vaccine Series

COVID-19 primary series is mandatory. Proof of COVID-19 vaccination must be documented below. A copy of your government-issued vaccine certificate must also be submitted.

First Dose

Date Given (mm/dd/yyyy)

HCP Initials:

Second Dose

Date Given (mm/dd/yyyy)

HCP initials:

Part 3: Varicella (Chicken Pox or Shingles)

The student must show proof of two (2) doses of Varicella Vaccinations completed at least one month apart or **Serology results for Varicella showing immunity**. If providing Serology results, the Healthcare Provider must attach a copy of the results (A history of chicken pox is not sufficient).

Healthcare providers please fill out the dates and indicate immune or non-immune. Please attach a copy of the blood work results.

Communicable Disease Information:

Varicella

Date of Serology Results (mm/dd/yyyy):

Immune or Non-immune:

HCP Initials:

Please provide two (2) Varicella vaccination dates below if blood work results were non-immune or indeterminate. One of these vaccinations must be a booster dose (vaccination given post-blood work).

Varicella Vaccination Dates:

1st Vaccination Date (mm/dd/yyyy):

HCP Initials:

2nd Vaccination Date (mm/dd/yyyy):

HCP Initials:

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Part 4: Diphtheria, Tetanus, Polio

Documentation of the completed primary series is required. Records of childhood vaccinations can be obtained by calling the Public Health Department located where you last attended school.
Routine Childhood Immunizations include all three of these vaccines. If the student did not receive childhood vaccines, please refer to the required schedule to start an unimmunized adult series.

Healthcare providers please fill out the dates and indicate yes or no:

a) Received Routine childhood immunizations: Yes No

b) Date of most recent Tdap/Td Booster dose (mm/dd/yyyy):
Must be within the last 10 years

HCP Initials:

If the student did not receive childhood vaccines, please provide dates of vaccinations received through the adult series. If the series is not completed, please indicate the scheduled dates of all vaccinations.

Diphtheria, Tetanus, Polio Adult Series Vaccination Dates:

1st Vaccination Date (mm/dd/yyyy):

HCP Initials:

2nd Vaccination Date (mm/dd/yyyy):

HCP Initials:

3rd Vaccination Date (mm/dd/yyyy):

HCP Initials:

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Part 5: Hepatitis B

Healthcare providers please fill out the dates and indicate immune or non-immune. Please attach a copy of the blood work results.

Section A:

Must complete all of Section A

Hepatitis B Vaccination Dates:

1st Vaccination Date (mm/dd/yyyy):

HCP Initials:

2nd Vaccination Date (mm/dd/yyyy):

HCP Initials:

3rd Vaccination Date (mm/dd/yyyy):

HCP Initials:

Hepatitis B (anti-HBs/HBsAB) blood work

Date of Serology Results (mm/dd/yyyy):

Immune or Non-Immune:

HCP Initials:

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Section B:

If the student is non-immune in section A, please complete section B.

If the student is non-immune to Hepatitis B, a booster dose or a completed second series of vaccinations may be required. Blood work results post booster, or second series must be enclosed and can be done one month after the final dose.

Hepatitis B Vaccination Dates:

1st Vaccination Date (mm/dd/yyyy):

HCP Initials:

2nd Vaccination Date (mm/dd/yyyy):

HCP Initials:

3rd Vaccination Date (mm/dd/yyyy):

HCP Initials:

Hepatitis B (anti-HBs/HBsAB) blood work:

Date of Serology Results (mm/dd/yyyy):

Immune or Non-Immune:

HCP Initials:

After having received a second series of Hepatitis B vaccine and having post-vaccination blood work, the student still does not show immunity and is a non-responder, therefore, will not require further immunizations.

HCP Signature: