



OFFICE USE ONLY	
CNP	G/M
Date:	____/____/____ year month day

IMMUNIZATION RECORD FORM FOR CONTINUING EDUCATION, PART-TIME AND FULL-TIME STUDIES

Trafalgar Road Campus Health Centre – Phone: 905-845-9430, ext.2550
Davis Campus Health Centre – Phone: 905-459-7533, ext. 5153

**ONLY FIRST YEAR students in the following programs are required to complete
and return this Immunization Record Form**

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Aromatherapy and Practical Applications (D) • Early Childhood Education (Diploma, Direct Entry) • Early Childhood Education (Supervision and Administration) (D) | <ul style="list-style-type: none"> • Educational Assistant • Esthetician • Montessori Early Childhood Teacher Education • Personal Support Worker (PSW) • Pharmacy Technician (D) | <ul style="list-style-type: none"> • Practical Nursing (D) • Social Service Worker - Gerontology <p>(D) = DAVIS</p> |
|--|--|---|

The information you provide is **confidential**. It is intended for use by Sheridan's Health Centre staff only to ensure that you meet the Health Centre requirements for your program. This information **will not** be released to anyone outside the Health Centre without your written permission.

- DAVIS**
 TRAFALGAR
 SKILLS TRAINING CENTRE (STC)
- FULL-TIME STUDIES**
 PART-TIME STUDIES (DAYTIME)
 PART-TIME STUDIES (CONTINUING EDUCATION)

Name _____ Gender M F Student Number _____
Last First

Program _____ Email Address _____

Phone and/or Cell Number () _____ Date of Birth ____/____/____
year month day

Address (During College Year) _____ City _____

Health Number _____ Version Code _____ Expiry Date _____ Postal Code _____

Your Name (exactly as on card) _____

Address of Subscriber (if out of province) _____

Notify in Emergency _____ Phone () _____

Family Physician _____ City _____

Allergies Yes No If yes, please list and indicate which (if any) are life threatening and require an epi-pen.

PLEASE NOTE: THERE IS A \$20 FEE TO REPRODUCE THIS FORM
 Complete and sign Immunization Record on reverse.
KEEP A COPY for your own records

- PLEASE COMPLETE AND SIGN THIS IMMUNIZATION RECORD -

Students **WILL NOT BE ALLOWED** on placement until **ALL** immunization information is completed and certificate of clearance is issued by the Health Centre.

The following immunization data is **COMPULSORY** upon registration at Sheridan. (*These requirements are based on recommendations established by the Ontario Hospitals Act, Days Nursery Act, Canadian Immunization Standards, Health Canada and the Halton/and Peel Medical Officers of Health.*)

- 1. Td**
- Tetanus, Diptheria, Polio - primary series YES NO If no, date of most recent TdP: _____
 - Tetanus, Diptheria - required every 10 years. Date of most recent booster: _____

2. MMR (Measles, Mumps, Rubella Vaccine) **CHOOSE (A) or (B)** ***proof required**

(A) Proof of one dose of Measles, Mumps, Rubella Vaccine and one additional dose of Measles Vaccine are required:

Measles, Mumps, Rubella Vaccine Date: _____ and Measles Vaccine Date: _____

OR

(B) Proof of immunity to Measles, Mumps and Rubella through a Measles, Mumps and Rubella titre (blood test). Results take 3-4 weeks. ***proof required**

Date: _____ Result - Immune to: MEASLES MUMPS RUBELLA ***Attach copy of result**

IF NOT IMMUNE TO ALL, you will require the MMR Vaccine (Measles, Mumps and Rubella). Date: _____

3. TUBERCULIN TESTING (T.B.) CHOOSE (A) or (B)

(A) 2-Step Tuberculin (T.B.) Skin Test required only once in a lifetime.

- MMR not to be given prior to testing
- **DO NOT TEST if previously Positive**
- BCG is not a contraindication ***proof required**

#1 Date: _____ Result (Read 48-72 hrs after test date): _____

mm induration

#2 Date: _____ Result (Read 48-72 hrs after test date): _____

mm induration

Given 1-3 weeks after #1

If Positive (10mm or more induration), chest x-ray is required within 12 months. Date: _____ Result: _____ ***Attach copy of result**

OR

(B) If you have had a documented 2-step T.B. test more than 1 year ago, only a 1-step T.B. test is needed. ***proof required**

Date: _____ Result (Read 48-72 hrs after test date): _____

mm induration

If Positive (10mm or more induration), chest x-ray is required within 12 months. Date: _____ Result: _____ ***Attach copy of result**

4. HEPATITIS B VACCINE – HIGHLY RECOMMENDED FOR ALL HIGH-RISK PROFESSIONS

Date #1: _____ Date #2: _____ and/or Date #3: _____ Post Vaccine Titre Level Result: _____ ***Attach copy of result**

5. Have you ever had the CHICKENPOX? YES NO

Varicella titre (blood test) – *Compulsory for Pharmacy Tech and Practical Nursing Programs.*

Date: _____ Result - Immune to: Non Immune: ***Attach copy of result**

IF NOT IMMUNE, Varicella vaccine is required for Pharmacy Tech and Practical Nursing Programs.

Date #1: _____ Date #2: _____ ***proof required**

6. Annual Flu Vaccine – Compulsory for Pharmacy Tech and Practical Nursing Programs. Date: _____ ***proof required**

ADDITIONAL INFORMATION

A) Have you had a BCG Vaccination for T.B.? (Students born in Quebec or outside of Canada) YES NO If yes, Date: _____

B) If T.B.test POSITIVE, INH Prophylaxis YES NO Dosage: _____ Duration: x _____ Months

The statements given above are true to the best of my knowledge and belief.

I, _____, UNDERSTAND THAT MISSTATEMENT IS GROUNDS FOR CANCELLATION OF ADMISSION.
print name

I UNDERSTAND THAT THE COLLEGE HAS THE RIGHT TO CANCEL MY ADMISSION PRIVILEGE ON THE BASIS OF MEDICAL INFORMATION SUBMITTED OR WITHHELD. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE APPROPRIATE SHERIDAN PERSONNEL OF ANY COMMUNICABLE DISEASE, SPECIAL NEED, OR MEDICAL CONDITION WHICH MAY PLACE ME AT RISK OR POSE A RISK TO OTHERS AT SHERIDAN OR ON PLACEMENT.

Student's Signature: _____ Date: _____

PLEASE COMPLETE ALL INFORMATION REQUESTED AND RETURN/FAX TO:

Sheridan Health Centre, Davis Campus, 7899 McLaughlin Road, Brampton, ON L6V1G6, FAX: 905-459-1694

or

Sheridan Health Centre, Trafalgar Campus, 1430 Trafalgar Road, Oakville, Ontario L6H 2L1, FAX: 905-815-4012

Freedom of information and Protection Privacy Act 1987. The information on this form is collected under the legal authority of the Colleges and Universities Act, R.S.O.1980, C272, S5; Regulated Health Professions Act. 1991, s.36(1) for use by Health Centre Staff. This information is used for administrative purposes. For further information, please contact Manager, Student Development and Wellness, Student Services, Sheridan College, 1430 Trafalgar Road, Oakville, ON L6H 2L1 (905) 845-9430, ext. 2031.