Toronto Metropolitan University

School of Early Childhood Studies
Faculty of Community Services

CLD 161 IMMUNIZATION FORM

As part of the School of Early Childhood Studies' non-academic documentation for field placements, and as required by our field placement partners, students must be free of communicable diseases.

This is necessary to ensure that our students protect their own health and safety, and the health and safety of children, families, visitors, employees and other students at the placement site.

****Our placement partners determine if students meet their immunization standards and have the right to refuse students who do not meet them.** **

If, for medical reasons, a student is unable to receive a required immunization, a Statement of Medical Exemption must be completed.

ALL sections of this form must be completed as outlined by a healthcare provider.

Student Name:	**TMU Student ID #:**

All students must provide **proof** of a Two [2]-Step TB Skin Test.

Check one:

☐ If the student has **never** had a Two [2]-Step TB Skin Test, a mandatory **2-Step Test** is required regardless of BCG History **(Step 2 must be completed within 6 months of the placement start date).**

☐ If the student has **proof** of a previous Two [2]-Step TB Skin Test and the results of both steps were **negative,** only complete the 1-Step TB Skin Test **(Step 1 must be completed within 6 months of the placement start date).**

TUBERCULOSIS SCREENING			
TB Skin Test Step 1	**Date Administered (yyyy/mm/dd)**	**Date Read (yyyy/mm/dd)**	**Results (induration in mm)**
TB Skin Test Step 2	**Date Administered (yyyy/mm/dd)**	**Date Read (yyyy/mm/dd)**	**Results (induration in mm)**
Previous 2-step TB Skin Test with negative results (if applicable)	**Date Administered (yyyy/mm/dd)**	**Date Read (yyyy/mm/dd)**	**Results (induration in mm)**

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Student Name:
TMU Student ID #:

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If a student's result on *one* or *both* tests is positive, a chest X-ray must be completed. Documentation indicating the X-ray results and the absence of tuberculosis must be produced.

1. Does this student have signs/symptoms of active TB on physical examination? Yes ☐ No ☐
2. Chest X-ray (ATTACH report, valid every four [4] years) Yes ☐ No ☐
3. Date of assessment _____(yyyy/mm/dd)
   **note: assessment must be reviewed annually*

REQUIRED IMMUNIZATIONS

**placement sites may request to see further documentation/serology report(s)*

Measles, Mumps Rubella (MMR)	**2 doses required *or* full immunity**				
	Dose 1 (yyyy/mm/dd)	**Dose 2 (yyyy/mm/dd)**	**Immune/not immune/ serology attached (if applicable)**		
Varicella (Chicken Pox)	**2 doses required *or* full immunity**				
	Dose 1 (yyyy/mm/dd)	**Dose 2 (yyyy/mm/dd)**	**Immune/not immune/ serology attached (if applicable)**		
Polio	**Initial primary series completed? Yes ☐ No ☐ [if no, provide primary series 3 doses]**				
	Dose 1 (yyyy/mm/dd)	**Dose 2 (yyyy/mm/dd)**	**Dose 3 (yyyy/mm/dd)**	**Healthcare provider comments**	
Diphtheria, Tetanus & Pertussis (DTaP)	**Initial primary series completed? Yes ☐ No ☐ [if no, provide primary series 3 doses]** **Received one dose of DTaP after 18th birthday? Yes ☐ No ☐**				
	Dose 1 (yyyy/mm/dd)	**Dose 2 (yyyy/mm/dd)**	**Dose 3 (yyyy/mm/dd)**	**Booster (if applicable) (yyyy/mm/dd)**	**Healthcare provider comments**
Hepatitis B	**3 doses required *or* full immunity**				
	Dose 1 (yyyy/mm/dd)	**Dose 2 (yyyy/mm/dd)**	**Dose 3 (yyyy/mm/dd)**	**Booster (if applicable) (yyyy/mm/dd)**	**Immune/not immune/serology attached (if applicable)**
Influenza (Flu) [winter placements only]	**Date of Immunization (yyyy/mm/dd)**				

Student Name:
TMU Student ID #:

ALL sections of this form must be completed as outlined by a healthcare provider.

By signing below, I verify that _____ (name of student) has completed the following tests/immunizations and is able to fully participate in a Child Care Centre with children ages birth to 5 years of age:

☐ Tuberculosis Skin Test

☐ Measles, Mumps and Rubella (MMR)

☐ Varicella (Chicken Pox)

☐ Polio

☐ Diphtheria, Tetanus & Pertussis (DTaP) and/or DTaP Booster

☐ Hepatitis B

☐ Influenza (Flu) [winter placements only]

☐ Medically fit to fully participate in a Child Care Centre with children ages birth to 5 years of age.

ADDITIONAL COMMENTS

NAME OF HEALTH CARE PROVIDER	SIGNATURE	DATE OF COMPLETION (yyyy/mm/dd)

MEDICAL OFFICE STAMP

(must be included)