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.

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

****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.

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Name of Student:	**Student ID #:**

All students must provide **proof** of a Two Consecutive Step-TB Skin Test.

Check one:

☐ If the student has **never** had a Two Consecutive Step-TB Skin Test, it is mandatory that they complete a **Two Step-TB Skin Test.**

☐ If the student has **proof** of a previous Two Consecutive Step-TB Skin Test and the results of both steps were **negative,** only complete the Step 1-TB Skin Test **(Step 1 must be completed no more than 6 months prior to the placement start date).**

☐ If the student has proof of a previous Two Consecutive Step-TB Skin Test and one or both of the results were **positive**, the healthcare provider will complete an annual physical exam & answer questions 1-5 on page 3 of this form.

TO BE COMPLETED BY HEALTH CARE PROVIDER			
TB Skin Test Step 1	**Date Administered (yyyy/mm/dd)**	**Date Read (yyyy/mm/dd)**	**Induration**
TB Skin Test Step 2	**Date Administered (yyyy/mm/dd)**	**Date Read (yyyy/mm/dd)**	**Induration**
Previous Two Consecutive Step TB Skin Test (if applicable)	**Date Administered (yyyy/mm/dd)**	**Date Read (yyyy/mm/dd)**	**Induration**
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.			
Chest X-ray	**Date Administered (yyyy/mm/dd)**	**Date Read (yyyy/mm/dd)**	**X-ray Result/ Comments**

☐ **Chest X-ray (ATTACH a copy of the X-ray report, valid every four [4] years)**

1. History of disease? Yes ☐ No ☐ Date _____(yyyy/mm/dd)
2. Prior history of BCG vaccination? Yes ☐ No ☐ Date _____(yyyy/mm/dd)
3. Does this student have signs/symptoms of active TB on physical examination? Yes ☐ No ☐
4. INH Prophylaxis? Yes ☐ No ☐ Date _____(yyyy/mm/dd)
5. Specialist Referred? Yes ☐ No ☐ Date _____(yyyy/mm/dd)

TO BE COMPLETED BY HEALTH CARE PROVIDER

Tetanus, Diphtheria, Acellular Pertussis (dTap)	**Date of Immunization (yyyy/mm/dd)**	**Booster (every 10 years) (yyyy/mm/dd)**	**Immune/not immune/ undetermined**	
Measles, Mumps Rubella (MMR)	**Date of 1st Immunization (yyyy/mm/dd)**	**Date of 2nd Immunization (yyyy/mm/dd)**	**Immune/not immune/ undetermined**	
Varicella	**Date of 1st Immunization (yyyy/mm/dd)**	**Date of 2nd Immunization (yyyy/mm/dd)**	**Immune/not immune/ undetermined**	
Hepatitis B	**Date of 1st Immunization (yyyy/mm/dd)**	**Date of 2nd Immunization (yyyy/mm/dd)**	**Date of 3rd Immunization (yyyy/mm/dd)**	**Immune/not immune/ undetermined**
Influenza (winter placements only)	**Date of Immunization (yyyy/mm/dd)**			

TO BE COMPLETED BY HEALTH CARE PROVIDER

Medical Office Stamp

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

☐ Tetanus, Diphtheria and Acellular Pertussis (dTap) and/or Td Booster

☐ Measles, Mumps and Rubella (MMR)

☐ Varicella

☐ Hepatitis B

☐ Annual Influenza Vaccine (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)