North Bay Regional Health Centre | Centre régional de santé de North Bay

Immunization/Immunity Form
CO-OP STUDENTS

Name:	**Date of Birth:**
Address:	
Phone:	**Email:**

PARENTAL CONSENT (For Applicants Under 18 years of Age)

Before starting co-op placement, I understand my child/dependent will be referred to the Health Centre's Occupational Health Department for health clearance and may require testing, such as; bloodwork and 2 step TB skin testing. I also understand and agree that if my child/dependent require any immunizations, they will be directed to; the Health Unit, family physician or clinic, in the Community and proof of immunization will be provided to Occupational Health prior to their start date.

Name of Parent/Guardian_____

Signature of Parent/Guardian _____ Date:_____

Tuberculosis Testing	Nurse's Notes
☐ Proof of 2-step Tb test 1) Date given: _____ Date read: _____ Result: _____ 2) Date given: _____ Date read:_____ Result: _____ ☐ If previous 2-step in past then annual TB test within last 12 months is required Date of Annual TB test: _____ Date read: _____ Result: _____ ☐ If positive TB test please provide GP/NP proof that you are free of active TB I confirm that this individual is free of active TB: Signed: _____ Date: _____	

Measles/Mumps/Rubella (one of the following)	Nurse's Notes
☐ Proof of 2 doses of MMR on/after First birthday or Lab Evidence of Immunity 1) Date of 1st dose: _____ 2) Date of 2nd dose: _____ (given at least 1 mo after 1st dose) **OR:** ☐ Lab evidence of immunity to: 1) Measles Date: _____ Result: _____ 2) Mumps Date: _____ Result: _____ 3) Rubella Date: _____ Result: _____	

Chicken Pox/Varicella (one of the following)	Nurse's Notes
☐ Confirmation of Lab Evidence of Immunity or Receipt of 2 Vaccines: Lab evidence of immunity: Date: _____ Result: _____ ☐ Proof of 2 Varicella Vaccines: 1) _____ 2) _____	

Covid Vaccination
☐ Dose 1 Date: _____ Pfizer ☐ Moderna ☐ Other _____
☐ Dose 2 Date: _____ Pfizer ☐ Moderna ☐ Other _____

Tetanus/Diptheria/Pertussis
☐ Date of last tetanus immunization: _____

Influenza Vaccination	Nurse's Notes
☐ Proof of annual influenza vaccine to be provided to Occupational Health annually: Date given: _____ ☐ Provide proof of medical contraindication if not able to receive the vaccine: Proof obtained? _____ (YES./NO)	

Hepatitus B Vaccines	Nurse's Notes
☐ Proof of completed Hepatitis B Immunizations Those vaccinated as child/adolescent may only require (2 doses required) 1) _____ 2) _____	

Comments:	
Nurse Signature:	**Date:**
Volunteer Signature:	**Date:**