



COMPLETION OF THIS FORM IS YOUR RESPONSIBILITY:
An incomplete form will prohibit your participation in the field placements that are a necessary component of your program.
KEEP A COPY FOR YOUR RECORDS.

MAIL OR DROP OFF COMPLETED FORMS TO:

ST. LAWRENCE COLLEGE
Campus Health Centre
100 Portsmouth Ave., Kingston, ON K7L 5A6

SECTION A To be completed by student – Please Print

Last Name First Name Middle Name Student Number

Male Female

Birth Date Yr. / Mo. / Day Gender PROGRAM

()

Home Address Street City Postal Code Phone

Email

Local Address (during school year)

()

Notify in Emergency Phone

()

Family Physician Name Phone

Attention Student: CONSENT FOR RELEASE OF INFORMATION

I understand and agree that my immunization record will be released to placement agencies, student service reps., program co-ordinators, faculty, Deans and Associate Deans, and the Public Health Department as required.

Signature

Date

For Office Use Only

HEALTH CARD NO. & VERSION CODE: _____

SECTION B Immunization Record To be completed by a Physician/Nurse

Attn Physicians: The immunization protocols have been adjusted to reflect the standards developed jointly by the Ontario Hospital Association, the Ontario Medical Association and approved by the Minister of Health – Communicable Disease Surveillance. All St. Lawrence College students and staff who will be in field placement and clinical settings such as hospitals, nurseries, daycare centres, and correction facilities **must submit a completed and signed** immunization record.

Student Name: _____ **Date of Birth:** _____

Tuberculosis: BCG Yes No Date: _____

Tuberculin Skin Test: 1. Date: _____ Date Read: _____ Result: _____
 2. Date: _____ Date Read: _____ Result: _____

***If positive, please submit a chest x-ray report within 2 years accompanied by a letter of assessment.**

Tetanus/Diphtheria/Pertussis Date: _____

Polio (Med Lab Students only) Date: _____

MMR #1 Date: _____

#2 Date: _____ (if applicable)

Rubella Titre Date: _____ Result _____

Measles Titre Date: _____ Result _____

Mumps Titre Date: _____ Result _____

Varicella Titre Date: _____ Result _____

Hep B #1 Date: _____

#2 Date: _____

#3 Date: _____

Titre Date: _____ Result _____

Typhoid (Med Lab Students only) Date: _____

Meningitis (recommended) Date: _____

SIGNATURES (mandatory)

Signature of Physician/Nurse: _____ **Date:** _____ **Clinic Stamp:** _____