CENTRE FOR HEALTH AND SOCIAL PRACTICE

Wintec
WAIKATO INSTITUTE OF TECHNOLOGY
Te Kuratini o Waikato

Immunisation Status and Vaccination Declaration - 2020

Students are required to provide information about their immunity for clinical placement. Your GP or delegated health professional may have evidence of vaccinations from your medical records. If you do not have evidence of vaccinations, blood testing is required to ascertain your immunity. **If not immune, vaccination/treatment is required as District Health Boards will not accept unvaccinated students for clinical placements**. (Students must meet the costs of any screening, treatment or vaccinations required).

1. **Student** completes **only** ID, name and details
2. Present this form to your **GP or delegated health professional to complete and sign**
3. **Keep a hard copy and an electronic copy**
4. **Add completed form into the Midwifery Clinical Passport**

	Wintec Student ID Number	
Full Name:		
Date of Birth:		

(day) (month) (year)

FOR GP or HEALTH PROFESSIONAL TO COMPLETE:

Wintec is required to hold documentary evidence of immunity and vaccination by health agencies/practitioners offering clinical placements to students. This information may be shared as necessary with appropriate health professionals and placement providers.

Please provide the following information for the above named midwifery student:

HEPATITIS B

Hep B – antigen Negative ☐ Positive ☐ **Hep B – antibody** Immune ☐ **Not immune** ☐
(continue with vaccination)

IF NOT IMMUNE –

If previous full Hep B course of immunisation

1. administer booster
   Date________________Initial _________

   Serology test results (3-4 weeks after later)
   Immune ☐ **Not immune** ☐
   (continue with 2nd full course)

2. If not immune
complete 2nd full course (2 further doses)

2nd dose Date________________Initial _________

3rd dose Date________________Initial _________

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Immune ☐ **Not immune** ☐

No previous Hep B vaccinations

1. administer full Hep B course

   1st dose Date________________Initial_________

   2nd dose Date________________Initial_________

   3rd dose Date________________Initial _________

   Serology test results (3-4 weeks after completion)
   Immune ☐ **Not immune** ☐
   (continue with Booster)

2. **If not immune** administer booster
   Date Initial

   Serology test results (3-4 weeks later)
   Immune ☐ **Not immune** ☐
   (continue with 2nd full course)

3. **If not immune** complete 2nd full course
   (2 further doses)

   2nd dose Date________________Initial _________

   3rd dose Date________________Initial _________

   Serology test results (3-4 weeks later)
   Immune ☐ **Not immune** ☐

Hepatitis B screening complete	**Date**______________**Initial** _________

MMR *(not applicable if born before 1969)*

Documented dates of two MMR vaccinations — 1st dose Date_______________Initial _________ / 2nd dose Date_______________Initial _________

OR

MEASLES Laboratory evidence of immunity — Immune ☐ **Not immune** ☐

MUMPS Laboratory evidence of immunity — Immune ☐ **Not immune** ☐

RUBELLA Laboratory evidence of immunity — Immune ☐ **Not immune** ☐

If not immune administer vaccination/s and document above

MMR Complete	**Date______________Initial ________**

VARICELLA

Diagnosis or verification of a history of varicella zoster by a health professional — Date __________

or

Documented administration of two doses of varicella vaccine — 1st dose Date___________Initial ________ / 2nd dose Date__________ Initial ________

or

Laboratory evidence of immunity or laboratory confirmation of disease — Immune ☐ **Not immune** ☐

If not immune administer vaccination/s and document above

Varicella complete	**Date______________Initial ________**

Boostrix (Diptheria/Tetanus/Pertussis) Documented evidence of administration within the last 10 years.	**Date______________Initial ________**

TB screening

Quantiferon Gold test result — Negative ☐ **Positive** ☐

If Positive Quantiferon Gold – Physical assessment by Doctor required, investigation:____

TB complete	**Date______________Initial ________**

MRSA Swabs required if the patient

Has a previous history of MRSA colonisation

Suffers from Hay Fever or Bronchiectasis

(When swabs are required, must have two taken, from the nose, groin and any open skin lesion/wound (e.g. infected fingernails) or active areas of psoriasis or eczema).

Swabs required:

No ☐ Date_________Initial_______

Yes ☐ Date_______________

Result_________________________

MRSA positive treatment completed	**Date______________Initial ________**

Skin Integrity: lower arms and hands –

Health Practitioners Competence Assurance Act 2003, 45 Subsection (5)

Does the student have any current skin conditions, and/or past history of contact dermatitis eczema or psoriasis, that may **not allow frequent contact with water, soap disinfectant and cleaning chemicals**?

No ☐ Yes ☐ **Initial** ________

The health professional hereby declares that all of the above information is correct.	
Name and MCNZ No of the GP or Health Professional and NCNZ No who is completing this declaration _______________________________ # _________	Medical Practice name/address/stamp:
Signature _______________________	
Date _______________________	

Student will

1.**Complete** ID, name and details	2.Present this form to your **GP or delegated health profession to complete and sign**
3.**Keep a hard copy and an electronic copy**	4.**Add completed form** to Midwifery Clinical Passport on Moodle *Dec 2020*