CENTRE FOR HEALTH AND SOCIAL PRACTICE
IMMUNISATION DOCUMENTATION

Students are required to provide information about their immunity for clinical placement. Your GP or delegated health professional may have evidence of your vaccinations. If you do not have evidence of vaccinations, blood testing is required to ascertain your immunity. If not immune, vaccination is required.
Note: Cost of any screening, treatment or vaccinations required are the student's responsibility.

It is advised that students keep a hard copy and an electronic copy for future reference if needed.
Please upload this form onto Sonia once completed.

FOR STUDENT TO COMPLETE:	
Full name:	
Date of Birth: DD / MM / YYYY	Student ID Number:

Privacy statement: Any information you provide is confidential to Wintec and no details, other than your overall clearance status, will be shared without your prior consent. Wintec is required to hold evidence of immunity and vaccination for health agencies / practitioners offering clinical placements to students.

FOR GP or HEALTH PROFESSIONAL TO COMPLETE:

HEPATITIS B

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

***IF NOT IMMUNE**:-

Previous full Hep B course of immunisation:

1. **If not immune** administer challenge dose
Date _____ Initial _____

Serology test (3-4 weeks 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 _____

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

2. **If not immune** administer challenge dose
Date _____ Initial _____

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

Hepatitis B screening complete **Date** _____ **Initial** _____

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MMR *(not applicable if born before 1969*)

Documented dates of two MMR vaccinations — 1st dose Date _____ Initial _____

OR

2nd dose Date _____ Initial _____

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 _____ Initial_____

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 ☐ Equivocal ☐ repeat blood test in 1 month

Quantiferon Gold test result : Positive ☐

GP appointment for referral for Chest Xray & Bloods — Yes ☐ No ☐

Chest Xray & Bloods normal & Asymptomatic — Yes ☐ No ☐

GP has informed patient that they have a latent Tuberculosis infection and the patient has declined to persue chemoprohylaxis. No referral to respiratory required. ☐

Patient referred to respiratory clinic ☐

TB complete Date _____ Initial _____

Swabs required:

MRSA Swabs required if patient:
has a previous history of MRSA colonisation or suffers from Hay Fever of Bronchiectasis — Yes ☐ No ☐ Date _____ Initial _____

Yes ☐ No ☐ Date _____ Initial_____

(Swabs; Must have two swabs taken: from nose & groin) Negative ☐ Date __ _____ Initial _____

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 _____

Covid-19 Vaccinations
Primary Doses:

Dose one	Date _____	Initial _____
Dose two	Date _____	Initial _____
Booster:	Date _____	Initial _____

The GP / 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. Name: No.: Signature: Date:	Medical Practice name/ address/ stamp: