# Canadian Association for Enterostomal Therapists
# Enterostomal Therapy Nursing Education Program (ETNEP)

**Occupational Health and Infectious Diseases:**
**Preclinical Placement Requirements for ETNEP Students**

This document outlines immunization and other occupational health requirements that ETNEP students need before they begin any clinical placement in a health facility through the course of ETNEP program.

The medical literature documents the potential for health care workers to acquire infections, both in and outside the workplace, and for them to transmit infection to patients, co-workers, and family members.[1,2,3,4] These infections may be spread through the airborne route (e.g. tuberculosis, varicella, measles), droplets (e.g. respiratory syncytial virus, influenza, rubella, pertussis), contact (e.g. hepatitis A, group A streptococcus), and mucosal or percutaneous exposure (e.g. hepatitis B and C, HIV).[5] The majority of these vaccine preventable infections may be transmitted from person-to-person. With that in mind, both the Steering Committee on Infection Control Guidelines and the National Advisory Committee on Immunization have provided recommendations for health care worker immunization.[6]

The following forms (ETNEP Student Immunization Record and Mandatory Tuberculosis Skin Test) are to be completed by a health care professional (physician, nurse practitioner, public health nurse or pharmacist) prior to your commencement of clinical learning experiences (ETNEP preceptorship). It is advised that all of your immunizations be up-to-date before you begin your program as some immunization schedules take several months to complete. Please read the form carefully as there are different documentation requirements for some of the diseases. You will be required to comply with all requests for documentation. Please present the completed forms (Pages 2,3,4) to the ETNEP administrative assistant prior to starting the ETNEP program. It is your responsibility to ensure that throughout the program your records are kept up to date.

We hope that you enjoy your program!

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[1] Health Canada. Prevention and control of occupational infections in health care. CCDR 2002; 28S1.

[2] Sepkowitz K.A. Occupationally acquired infections in health care workers. Part 1. Ann Intern Med 1996; 125:826-34.

[3] Sepkowitz K.A. Occupationally acquired infections in health care workers. Part II. Ann Intern Med 1996; 125:917-28.

[4] Patterson W.B., Craven D.E., Schwartz D.A., Nardell E.A., Kasmer J., Noble J. Occupation hazards to hospital personnel. Ann Intern Med 1985; 102:658-80.

[5] Health Canada. Routine practices and additional precautions for preventing the transmission of infection in health care.CCDR 1999; 25S4.

[6] Health Canada. Canadian Immunization Guide. https://www.canada.ca/en/public-health/services/canadian-immunization-guide.html and https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-3-vaccination-specific-populations/page-11-immunization-workers.html

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Please see below the list of immunization requirements for ETNEP students. Please have a health care professional (physician, nurse practitioner, public health nurse or pharmacist) complete the form indicating your **present** immunization status. Please double check that the form is fully complete prior to submitting to the ETNEP administrative office.

Failure to complete this form will delay entrance into preceptorships and possible delay your completion of the ETNEP program. Students may NOT enter clinical preceptorship without completion of this form. Students are responsible for the costs of vaccines, mantoux/TB and blood tests, if applicable.

| **First Name (please type or print)** | **Last Name (please type or print)** |
|---|---|
| | |
| **Date of Birth** | |
| DD/MM/YY | |

| **MANDATORY MMR Requirements**<br>*Please note the mandatory 2-step TB skin test should be done 4-6 weeks before/after the administration of an MMR.* | |
|---|---|
| Documentation record of two MMR vaccinations at least one month apart<br>OR | DD/MM/YY<br>DD/MM/YY |
| If you are unable to document 2 MMR vaccinations a booster is required | DD/MM/YY |

| **MANDATORY Varicella (Chicken Pox/Shingles) Requirements** | |
|---|---|
| Documented history of Varicella (Chicken Pox/ Shingles)?<br>OR<br>If history is uncertain, attach serology report demonstrating immunity to naturally acquired Varicella. Please do not order serology if student is vaccinated or will be vaccinated. | ☐<br>☐ |
| Documented record of two doses of Varicella vaccination given at least one month apart. Please do not order serology after vaccination. | DD/MM/YY<br>DD/MM/YY |

| **MANDATORY Tetanus, Pertussis and Diphtheria Requirements** | |
|---|---|
| Documentation of dose of tetanus, diphtheria and pertussis vaccine, administered within the PAST TEN YEARS (e.g. Adacel™ or Boostrix™). Please provide a booster if needed. | DD/MM/YY |

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| **MANDATORY Hepatitis B Requirements (PART A)** | |
|---|---|
| Documentation of Hepatitis B vaccination series (3 Doses)<br>AND | DD/MM/YY |
| | DD/MM/YY |
| | DD/MM/YY |
| HBsAb (Anti –HBs) Bloodwork Titre Level Result -taken at least 4-8 weeks after immunization. (Please attach copy of Serology lab report results) | Results |
| | DD/MM/YY |

***If titre results above show you are not immune to Hepatitis B, it is mandatory to complete Part B (see below***

| **Hepatitis B Repeat Series (PART B)**<br>**To be completed if tire results in PART A signify non-immunity** | |
|---|---|
| Dose of 1 Repeat Series | DD/MM/YY |
| *Serology may be taken one month after first dose of repeat series to assess immunity if original series was completed more than 6 months prior to a negative HBsAb test.* | |
| Dose of 2 Repeat Series | DD/MM/YY |
| Dose of 3 Repeat Series | DD/MM/YY |
| Repeat HBsAb (Anti –HBs) Bloodwork Titre Level Result -taken at least 4-8 weeks after immunization. (Please attach copy of Serology lab report results) | Results |
| | DD/MM/YY |

| **RECOMMENDED Annual FLU Vaccination** | |
|---|---|
| Date of most recent annual flu vaccination | DD/MM/YY |

| **Polio**<br>**MANDATORY if lived/ visited a country in which there has been a recent Polio outbreak.** | |
|---|---|
| Documentation of Primary Series | DD/MM/YY |

Name of Healthcare Professional or Public Health Official — Phone Number

DD/MM/YY

Signature — Date

*Please have a health care professional complete one of the below options indicating your current status:*

**MANDATORY TUBERCULOSIS SKIN TEST (TST)**

Name (Please Print)

Banner Number

**A No Record of Previous 2 Step TST**

Provide Dates & Results of 2 Step TST below:

| Dates Planted | | Dates Read | |
|---|---|---|---|
| Step 1 | DD/MM/YY | 1st Date | DD/MM/YY |
| | | Results | |
| Step 2 | DD/MM/YY | 2nd Date | DD/MM/YY |
| | | Results | |

**B Record of Previous 2 Step TST *Within Last 12 Months***

Attach Documentation of the previous 2 step TST with dates and results:

Documentation Attached (Y/N) ☐

**C Record of Previous 2 Step TST *More Than 12 Months Ago***

1 Step TST & Documentation of the previous 2 step TST:

| Date Planted | DD/MM/YY | | |
|---|---|---|---|
| Date Read | DD/MM/YY | Results | |

Documentation Attached (Y/N) ☐

**D Positive TST (Do not repeat test)**

Chest x-ray required for the following:

- ☐ Documented prior positive TST
- ☐ Previous Treatment for active TB
- ☐ Previous Treatment for latent TB

| Date | DD/MM/YY | Results | |
|---|---|---|---|

Documentation Attached (Y/N) ☐

**E TST Contraindicated**

Contraindications to TST include:

- ☐ History of severe blistering or Anaphylaxis from TST
- ☐ Previous Positive TST (See Choice E)
- ☐ Severe active viral infection
- ☐ Received a live virus vaccination in the past month (MMR)
- ☐ Other

If there is a contraindication to TST such as a documented prior positive TST, previous treatment for active TB, or previous treatment for latent TB ( See list above for more contraindications), a TST is not required—Medical evaluation and chest X-ray within 1 year are required.

***Please note: A prior BCG is not a contraindication.*** *If a BCG has been administered in the past, please follow options A, B, or C*

Signature of Healthcare Professional or Public Health Official

Date

Phone Number

https://cdn.dal.ca/content/dam/dalhousie/pdf/healthprofessions/School%20of%20Nursing/Clinical/Immunization%20Form%20Updated%202018.pdf