

# IMMUNISATION REPORT

## STUDENT INSTRUCTIONS

Before commencing clinical placement, you must provide evidence of immunity to some diseases. Please have this form completed and signed by a GP or Practice Nurse. If you do not have evidence of your vaccinations, serology testing (blood test) is required to confirm your immunity.

In the event you are not immune, vaccination / treatment will be necessary which will incur a cost.

- Once completed, please upload to your 'Checks' tab in MyWIL.
- Students must retain a hard copy and an electronic copy of this document.
- Please note any information you provide is confidential to the University and no details, other than your overall clearance status, will be shared without your prior consent.
- Any questions, email [nursingplacements@waikato.ac.nz](mailto:nursingplacements@waikato.ac.nz)

## STUDENT DETAILS

<b>Student Name:</b>	
<b>Student ID Number:</b>	
<b>Date of Birth (DD/MM/YYYY):</b>	
<b>NZ Mobile Number:</b>	
<b>Living Address during study:</b>	
<b>Personal Email Address:</b>	

## FOR GP OR HEALTH PROFESSIONAL TO COMPLETE

- The University of Waikato is required to provide evidence of immunity and vaccinations. This information will be shared as necessary with appropriate health professionals and placement providers.
- Please complete the following information for the above-named patient.
- There are 9 sections to complete. All must be completed in full.

**1) COVID-19**

Documented administration of two doses of COVID-19

1<sup>st</sup> dose    Date    Initial:  
2<sup>nd</sup> dose    Date    Initial:  
Booster     Date    Initial:

<b>COVID-19 Complete (Two doses)</b>	Yes <input type="checkbox"/>	<b>Initial:</b>
<b>COVID-19 Booster Complete (If recommended by <a href="#">NZ COVID Guidelines</a>)</b>	Yes <input type="checkbox"/> N/A <input type="checkbox"/>	<b>Initial:</b>

**2) HEPATITIS B**

Hepatitis B – Antigen <i>*if positive, student must inform nursing school &amp; clinician to manage per health pathways</i>	Positive* <input type="checkbox"/>	Negative <input type="checkbox"/>
Hepatitis B – Antibody <i>*Continue with vaccination</i>	Immune <input type="checkbox"/>	Not immune * <input type="checkbox"/>

**\* If not immune continue per below**

<p><b>Previous full Hep B course of immunisation:</b> 1. If not immune administer challenge dose Date _____ Initial _____</p> <p>Serology test results (3-4 weeks later) Immune <input type="checkbox"/> Not immune <input type="checkbox"/> (continue with 2<sup>nd</sup> full course)</p> <p>2. If not immune complete 2<sup>nd</sup> full course (2 further doses) 2<sup>nd</sup> dose Date _____ Initial _____ 3<sup>rd</sup> dose Date _____ Initial _____</p> <p>Serology test results (3-4 weeks later) Immune <input type="checkbox"/> Not immune <input type="checkbox"/></p>	<p><b>No previous Hep B vaccination:</b> 1. Administer full Hep B course 1<sup>st</sup> dose Date _____ Initial _____ 2<sup>nd</sup> dose Date _____ Initial _____ 3<sup>rd</sup> dose Date _____ Initial _____</p> <p>Serology test results (3-4 weeks after completion) Immune <input type="checkbox"/> Not immune <input type="checkbox"/> (continue with Booster)</p> <p>2. If not immune administer challenge dose Date _____ Initial _____</p> <p>Serology test results (3-4 weeks later) Immune <input type="checkbox"/> Not immune <input type="checkbox"/> (continue with 2<sup>nd</sup> full course)</p> <p>3. If not immune complete 2<sup>nd</sup> full course (2 further doses) 2<sup>nd</sup> dose Date _____ Initial _____ 3<sup>rd</sup> dose Date _____ Initial _____</p> <p>Serology test results (3-4 weeks later) Immune <input type="checkbox"/> Not immune <input type="checkbox"/></p>
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<b>Hepatitis B evidence of immunity complete</b>	<b>Date:</b>	<b>Initial:</b>
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**3) BOOSTRIX (DIPHTHERIA/TETANUS/PERTUSSIS)**

Documented evidence in the last 10 years	Date:	Initial:
<b>Boostrix evidence of immunity complete</b>	<b>Date:</b>	<b>Initial</b>

**4) MMR (MEASLES/MUMPS/RUBELLA) (NOT APPLICABLE IF BORN BEFORE 1969)**

<p><b>MMR</b> (not applicable if born before 1969)</p> <p>Documented dates of two MMR vaccinations</p> <p><u>OR</u></p> <p>MEASLES Laboratory evidence of immunity MUMPS Laboratory evidence of immunity RUBELLA Laboratory evidence of immunity</p> <p style="text-align: right;">If not immune administer vaccination/s and document above</p>	<p>1st dose Date _____ Initial _____</p> <p>2nd dose Date _____ Initial _____</p> <p>Immune <input type="checkbox"/> Not immune <input type="checkbox"/></p> <p>Immune <input type="checkbox"/> Not immune <input type="checkbox"/></p> <p>Immune <input type="checkbox"/> Not immune <input type="checkbox"/></p>	
<b>MMR evidence of immunity complete</b>	<b>Date:</b>	<b>Initial</b>

**5) VARICELLA (CHICKEN POX)**

<p>Diagnosis or verification of a history of varicella zoster by a health professional</p> <p><u>OR</u></p> <p>Documented administration of two doses of varicella vaccine 1st dose (6 weeks apart)</p> <p><u>OR</u></p> <p>Laboratory evidence of immunity OR laboratory confirmation of disease</p>	<p>Date _____</p> <p>1st dose Date _____ Initial _____</p> <p>2nd dose Date _____ Initial _____</p> <p>Immune <input type="checkbox"/> Not immune <input type="checkbox"/></p> <p>If not immune administer vaccination/s and document above</p>	
<b>Varicella evidence of immunity complete</b>	<b>Date:</b>	<b>Initial</b>

## 6) TUBERCULOSIS (TB)

QuantiFERON-TB Plus Gold test result	Negative <input type="checkbox"/> Positive <input type="checkbox"/> <b>If Positive</b> QuantiFERON Gold – GP referral to Respiratory Clinic required. To be cleared for Placement the student must provide a letter from GP stating student is symptom free.
<b>TB Screening complete</b>	<b>Date:</b> _____ <b>Initial</b> _____

## 7) 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 history of contact dermatitis, eczema or psoriasis, that may not allow frequent contact with water, soap disinfectant and cleaning chemicals?	Yes* <input type="checkbox"/> Date _____ Initial _____ No <input type="checkbox"/> Date _____ Initial _____ <i>*if yes, please note recommended action below</i>
<b>Skin Integrity exam complete</b>	<b>Date:</b> _____ <b>Initial</b> _____

## 8) NOTES

<i>Please add notes on any non-standard results and/or further actions required:</i>
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## 9) RECOGNITION OF FORM COMPLETION

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

**Note:** Students may be required to provide evidence of an annual Influenza vaccination during the declared influenza seasons when undertaking clinical placement.