

To progress to clinical placements, students must provide evidence of the necessary screening and immunity status to specific vaccine preventable diseases (VPD). Evidence of immunity to specific VPD is a mandatory requirement across all healthcare placement providers and complies with the [Addressing Vaccine Preventable Disease: Occupational assessment, screening, and vaccination](#) policy. Students may not be permitted to progress to clinical placement, without completion of this form. Once signed by an authorised immunisation provider, submit the completed form to InPlace for verification. Placement providers reserve the right to request students provide evidence of their screening / immunisation status, it is recommended that students keep electronic and hard copies of their final set of reports and documents as the University cannot provide these. If a student is a non-seroconverter or has a contraindication to a vaccine, they are to complete the *Incomplete Immunisation Declaration* section below with their Medical Practitioner (page 3).

Student Name: _____		Student ID: _____		Date of Birth: _____	
Vaccine Preventable Disease (VPD)	Accepted evidence of immunity	Completed & Practitioner Initials	Date/s of vaccine (as required)	Vaccine by (as required)	
Diphtheria, Tetanus and Pertussis (DTPa)^	Confirmed evidence of immunity by one documented dose of adult DTPa vaccine within the last 10 years.	<input type="checkbox"/> Initials: _____	Date: _____	Sign: _____	
Measles, Mumps And Rubella (MMR)^	Confirmed evidence of immunity to Measles AND Mumps AND Rubella. OR	<input type="checkbox"/> Initials: _____			
	Confirmed course of two (2) doses of MMR given at least 28 days apart (both doses given before tick box is selected).	<input type="checkbox"/> Initials: _____	Dose 1: _____ Dose 2: _____	Sign: _____ Sign: _____	
Varicella zoster virus (VZV) (Chickenpox)^	Confirmed evidence of immunity to VZV OR	<input type="checkbox"/> Initials: _____	Serology report provided to student <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Confirmed course of two (2) doses of VZV given at least 28 days apart (both doses given before tick box is selected).	<input type="checkbox"/> Initials: _____	Dose 1: _____ Dose 2: _____	Sign: _____ Sign: _____	
Hepatitis B**	Confirmed evidence of immunity to Hepatitis B with surface protective antibodies of >10 IU/L following primary course. OR	<input type="checkbox"/> Initials: _____	Final Serology report confirming immunity completed and provided to student <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Confirmed course of three (3) doses of Hepatitis B commenced (booster if required) (serology report to student upon completion).	<input type="checkbox"/> Initials: _____	Dose 1: _____ Dose 2: _____ Dose 3: _____ Booster (if required):	Sign: _____ Sign: _____ Sign: _____ Sign: _____	
Poliomyelitis^	Confirmed evidence of immunity to Poliomyelitis vaccinations <u>or</u> Statutory Declaration confirming have received Polio vaccinations OR	<input type="checkbox"/> Initials: _____			
	Confirmed courses of three (3) doses of polio vaccine given four weeks apart.	<input type="checkbox"/> Initials: _____	Dose 1: _____ Dose 2: _____ Dose 3: _____	Sign: _____ Sign: _____ Sign: _____	
Hepatitis A* (recommended)	Confirmed evidence of immunity to Hepatitis A OR	<input type="checkbox"/> Initials: _____	Serology report provided to student <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Confirmed course of two (2) doses of Hepatitis A commenced	<input type="checkbox"/> Initials: _____	Dose 1: _____ Dose 2: _____	Sign: _____ Sign: _____	

Important notes: ^DTPa, MMR, VZV and Poliomyelitis do not require confirmation of immunity post-vaccination; *Hepatitis A is only recommended for students working in Indigenous communities or with Indigenous children, and for carers of people with developmental disabilities. Discuss with your medical practitioner if you are concerned; **Hepatitis B requires confirmation of immunity post-vaccination for all students after completion of vaccination course. All students are required to have serology.

Medical / Nurse Practitioner Declaration:

I confirm that I have assessed the immunisation history and needs of this student and report their immunisation status is as follows:

COMPLETED Student has completed all vaccination requirements and has serological evidence of immunity (where required)	COMMENCED Student has commenced a vaccination schedule for one or all required VPD's as listed but has outstanding requirements.	MEDICAL CONTRAINDICATION Student has not seroconverted or has a confirmed medical contraindication to vaccination. Complete page 3 of this form.
Signed: Date: <div>Practice Stamp or address</div>	Signed: Date: <div>Practice Stamp or address</div>	Signed: Date: <div>Practice Stamp or address</div>

Prescribed Communicable Infection Screening: Applicable to Medicine and Dental Programs only

Hepatitis C Virus (HCV)	Screening Test Done <input type="checkbox"/> Practitioner Initials: Date:	If screening for HCV or HIV is positive, the student is not required to inform SA Health, confidential medical and career advice must be sought from an Infectious Diseases Physician and the Dean of the relevant School informed.
Human Immuno-deficiency Virus (HIV)	Screening Test Done <input type="checkbox"/> Practitioner Initials: Date:	

Tuberculosis Screening:

Students must complete the [SA Health Online Tuberculosis Screening Questionnaire](#). It is recommended students complete this prior to receiving vaccinations as are unable to complete a TB Screening within 4 weeks of having a live vaccination.

Student declaration:

- I have completed the online questionnaire and have been assessed as low risk and do not require a follow-up appointment

☐

OR

- I have completed the online questionnaire; I was assessed as high risk and have received follow-up with SA Health TB Services and received clearance for placement

☐**Student Declaration of Compliance:**

- ☐ I have read and understand the requirements of the [Addressing Vaccine Preventable Disease: Occupational assessment, screening, and vaccination](#), and understand that if I am non-compliant with evidence of immunisations that I will not proceed to clinical placement.
- ☐ I understand that I may be required to produce my immunisation records (Compliance Certificate, vaccination records and or serology reports) for sighting by placement providers in accordance with these directives.
- ☐ I declare that the information provided in this form is true and correct and is the original copy. I understand that Adelaide University will initiate disciplinary proceedings according to institutional protocols if there is evidence that I have provided which is incorrect, misleading, fraudulent, or false.

Student Name: _____ Student ID: _____

Program Completing: _____

Signature: _____ Date: _____

PLEASE COMPLETE THIS SECTION OF THE FORM WITH YOUR MEDICAL PRACTITIONER IF YOU ARE UNABLE TO FULFILL ALL REQUIREMENTS FOR IMMUNISATION DUE TO MEDICAL CONTRAINDICATION TO VACCINATION OR FAILURE TO SEROCONVERT POST RECEIPT OF VACCINE.

Position Statement: All Health Care and Education Providers have a duty of care to ensure a safe work environment for all health care workers (HCWs), other employees, patients/clients, and visitors. It is a requirement that all HCWs (including students) comply with the Addressing Vaccine Preventable Disease: Occupational assessment, screening and vaccination.

STUDENT HEALTHCARE WORKER DECLARATION:

I, (print full name) _____ have discussed immunisation requirements with my immunisation provider and have made every effort to meet these requirements. I understand that by not being able to meet the immunisation requirements, I may remain non-immune to vaccine preventable diseases, may be at risk of infection with these diseases, and may continue to be a potential source of infection to other HCWs, patients, staff, and visitors. As a result of not achieving full compliance with the immunisation requirements, I understand that a risk assessment of my current immune status against my program requirements will be conducted, and I will be advised of options to manage the risk. I understand that my status may impact upon where I may be able to undertake placement and that I will be required to engage with Addressing Vaccine Preventable Disease: Occupational assessment, screening and vaccination to maintain the safety of myself and all others that I come in contact with. I understand that this information may be shared with the relevant Program Director and/or Course Coordinator for further consultation and development of a plan for progression.

STUDENT ID: _____ DATE OF BIRTH: ____/____/____

STUDENT SIGNATURE: _____ DATE: _____

MEDICAL PRACTITIONER STATEMENT:

I confirm that this student has engaged with my services to achieve the required immunisation standards as outline in the Addressing Vaccine Preventable Disease: Occupational assessment, screening and vaccination policy and is unable to meet the immunisation standards for the following reason:

- ☐ Permanent medical contraindication to vaccination
- ☐ Temporary medical contraindication to vaccination
Date student will be able to obtain vaccination (if known) ____/____/____
- ☐ Failure to seroconvert post receipt of vaccine.

Vaccination Contraindication is for: _____

Medical Practitioners Name: _____

Signature: _____ Date: _____