

CERTIFICATE OF COMPLIANCE – Immunisations & Blood Borne Virus Policy

Last Name: Enter Text

First Name: Enter Text

Date of Birth (dd/mm/yyyy): Enter Text

Qualification: Choose an item.

Student ID: Enter Text

Instructions for Student Health Care Workers: This form **must be** completed before you will be permitted to commence clinical placement.

VPD	Immune	Not Immune	Blood test result or date vaccination given	
Chicken Pox (Varicella-Zoster Virus)	<input type="checkbox"/> Confirmed by history of past infection <input type="checkbox"/> Confirmed by blood test result <input type="checkbox"/> Confirmed by vaccination record	<input type="checkbox"/> Serological testing recommended <input type="checkbox"/> Vaccination recommended	Blood test result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune	
			Vaccine (dose 1) given: <input type="checkbox"/> Yes <input type="checkbox"/> No Vaccine (dose 2) given: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: Date:
Diphtheria, Tetanus and Pertussis (dTpa)	<input type="checkbox"/> Confirmed by vaccination record of booster dose	<input type="checkbox"/> Vaccination recommended (booster)	Vaccine (booster) given: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Hepatitis A*	<input type="checkbox"/> Confirmed by history of past infection <input type="checkbox"/> Confirmed by vaccination record <input type="checkbox"/> Confirmed by blood test result	<input type="checkbox"/> Serological testing recommended <input type="checkbox"/> Vaccination recommended	Blood test result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune	
			Vaccine (dose 1) given: <input type="checkbox"/> Yes <input type="checkbox"/> No Vaccine (dose 2) given: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: Date:
Hepatitis B Virus (HBV)	<input type="checkbox"/> Confirmed by blood test result	<input type="checkbox"/> Serological testing recommended <input type="checkbox"/> Vaccination recommended	Blood test result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune	
			Vaccine (dose 1) given: <input type="checkbox"/> Yes <input type="checkbox"/> No Vaccine (dose 2) given: <input type="checkbox"/> Yes <input type="checkbox"/> No Vaccine (dose 3) given: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: Date: Date:
Measles, Mumps, Rubella (MMR)	<input type="checkbox"/> Confirmed by vaccination record <input type="checkbox"/> Confirmed by blood test result <input type="checkbox"/> Confirmed by birth before 1966	<input type="checkbox"/> Vaccination recommended	Vaccine (dose 1) given: <input type="checkbox"/> Yes <input type="checkbox"/> No Vaccine (dose 2) given: <input type="checkbox"/> Yes <input type="checkbox"/> No	
			Date: Date:	
Poliomyelitis	<input type="checkbox"/> Confirmed by history of vaccination	<input type="checkbox"/> Vaccination recommended	Primary vaccination course started: <input type="checkbox"/> Yes <input type="checkbox"/> No	
COVID-19	<input type="checkbox"/> Dose 1 confirmed by vaccination record <input type="checkbox"/> Dose 2 confirmed by vaccination record <input type="checkbox"/> Dose - Booster confirmed by vaccination record	Date Administered: Date Administered: Date Administered:		
Instructions for Medical Practitioner: Please tick ONE OR MORE box for each vaccine preventable disease (if appropriate). Use the <i>Acceptable evidence of immunity to specific VPDs for Health Care Workers</i> table on the back of this form as a reference and complete the applicable declaration below				
In Progress: I confirm that the above-named person has commenced a course of vaccination (as indicated above) and will require further follow up.		Compliant: I confirm that the above-named person has provided me with evidence satisfying the above requirements.		
Name:	Signature:	Name:	Signature:	
Provider No:	Date:	Provider No:	Date:	

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Disease	Screening Test	
Hepatitis C Virus (HCV)	<input type="checkbox"/> Screening test done <input type="checkbox"/> No screening test done	HCWs need to know their HCV and HIV immune status (but do not need to inform SA Health of the result) If the screening test for HCV or HIV is positive, confidential medical and career advice should be sought from an Infectious Diseases Physician
Human Immunodeficiency Virus (HIV)	<input type="checkbox"/> Screening test done <input type="checkbox"/> No screening test done	
For student Health care Workers: the student has confirmed that they have completed the screening questionnaire provided by SA Tuberculosis Service		<input type="checkbox"/> YES <input type="checkbox"/> NO

Acceptable evidence of immunity to specific VPDs for Health Care Workers			
VPD	Acceptable Evidence of Immunity	VPD	Acceptable Evidence of Immunity
Chicken Pox (Varicella-Zoster)	Documented evidence of varicella antibody (IgG) on serology or documented evidence of varicella vaccination or a history of prior chickenpox or shingles (no documentation required for history of infection). Confirmation of immunity post-vaccination is not required.	Hepatitis B	Documented evidence of Hepatitis B core antibody or documented level of hepatitis B surface antibody (>10mIU/ml) following completion of a course of hepatitis B vaccine*. Confirmation of immunity post-vaccination is required after completion of the vaccination course for all HCW.
Diphtheria	Documented evidence of a booster dose of diphtheria-containing vaccine in the last 10 years. Confirmation of immunity post-vaccination is not required.	Mumps	Documented evidence of mumps antibody (IgG) on serology or documented evidence of 2 mumps vaccinations. Confirmation of immunity post-vaccination is not required
Hepatitis A*	Documented evidence of hepatitis A antibody on serology (IgG) or documented evidence of completed course of hepatitis A vaccine. Confirmation of immunity post-vaccination is not required.	Measles	Documented evidence of measles antibody (IgG) on serology or documented evidence of 2 measles vaccinations at least one month apart or born before 1966. Confirmation of immunity post-vaccination is not required.
Rubella	Documented evidence of rubella antibody (IgG) on serology or documented evidence of 2 rubella vaccinations. Confirmation of immunity post-vaccination is not required.	Poliomyelitis	History of vaccination with a primary course of 3 vaccinations (documentation is not required). Confirmation of immunity post-vaccination is not required.
Pertussis	Documented evidence of pertussis booster vaccination in the previous 10 years. Confirmation of immunity post-vaccination is not required.	Influenza	Documented evidence of influenza vaccination during the current influenza season. Confirmation of immunity post-vaccination is not required.
COVID-19	Documented evidence of an age-appropriate COVID-19 vaccination.	Tetanus	Documented evidence of a booster dose of vaccine containing tetanus in the last 10 years. Confirmation of immunity post-vaccination is not required.

*Hepatitis A: Screening and vaccination necessary for student health care workers who will be working in remote Indigenous communities or with Indigenous children. It is also recommended for students in childcare and preschool settings and carers of people with intellectual disabilities.

*All HCW who have lived in a hepatitis B endemic country for at least 3 months are required to have serology that includes hepatitis B surface antigen prior to vaccination. For a list of endemic countries (intermediate and high risk) please see: <https://wwwnc.cdc.gov/travel/yellowbook/2020/travel-related-infectious-diseases/hepatitis-b>

For further details see the current edition of the Australian Immunisation Handbook available from www.immunise.health.gov.au