**IMMUNISATION CHECKLIST**

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| **Employee (PRINT CLEARLY)** | |
| **Surname:** | **First name:** |
| **Address:** | |
| **Mobile:** | |
| **All sections of this form are mandatory and must be completed by your immunisation provider or the form will be rejected. This form must be completed and returned before commencement of Student placement** | |
| **GH VACCINATION / HEALTH SCREENING REQUIREMENT** | **ACCEPTABLE EVIDENCE OF IMMUNITY AND DOCUMENTATION**  **(Please tick box to indicate evidence provided)** |
| **HEPATITIS B** | * Evidence of completed vaccination course (3 doses).   **AND**   * Serology result indicating immunity to Hepatitis B. (Hepatitis B **antibody** level >10mIU/mL |
| **DIPTHERIA/TETANUS/ PERTUSSIS** | * One documented adult dose of **dTpa** vaccine within the last 10 years.   (**ADT vaccination is not acceptable)** |
| **MEASLES** | * Documented evidence of 2 doses of MMR vaccine given at least 4 weeks apart.   **OR**   * Documented evidence of positive IgG for Measles serology |
| **MUMPS** | * Documented evidence of 2 doses of MMR vaccine given at least 4 weeks apart.   **OR**   * Documented evidence of positive IgG for Mumps serology |
| **RUBELLA** | * Documented evidence of 2 doses of MMR vaccine given at least 4 weeks apart.   **OR**   * Documented evidence of positive IgG for Rubella serology |
| **VARICELLA** | * Documented evidence of 2 doses of Varicella vaccine given at least 4 weeks apart.   **OR**   * Documented evidence of positive IgG for Varicella serology |
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| **INFLUENZA** | * Annual Influenza vaccine |
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| **Service Provider / Nurse Immuniser Declaration** | |
| I, the undersigned declare that the immunisation requirements specified above have been assessed and actioned. | |
| **Service Provider / Nurse Immuniser Contact Details** | |
| Service Provider / Nurse Immuniser name and contact details (please print or stamp – illegible documentation cannot be accepted) | |
| **Date:** | **Signature:** |