Private Companion Program
3560 Bathurst Street
Toronto, ON, M6A 2E1,
Tel. 416-785-2500 ext. 3195
Email: fcossever@baycrest.org

APPENDIX D

Private Companion Immunization Record

Baycrest is committed to protecting your privacy. The Communicable Disease Protocols have been developed jointly by the Ontario Hospital association (OHA) and the Ontario Medical Association (OMA) and approved by the Minister of Health and Long-Term Care (MOHLTC). They were developed in compliance with Regulation 965, Section 4, under the *Public Hospitals Act*. This regulation requires each hospital to have by-laws that establish and provide for the operation of a health surveillance program including a communicable disease surveillance program in respect of all persons carrying on activities in the hospital.

INSTRUCTIONS: Once completed, submit this form to the Private Companion Program office which is on the 2nd floor of the Brain Health Complex, room 271, in person or by mail, fax or email. If you have questions concerning the completion of this form, please call the Private Companion office at 416-785-2500 extension 3195. Any costs associated with the completion of this form are the responsibility of the private companion. **Retain a copy for your records.** :

A. Identification

Name (First/Last): ____

Address: ____

City: _________________________ Province: _________________ Postal Code: ______________________

Telephone: (Home): ___________________________________ (Cell): ___________________________________

Date of Birth: ____ ☐ Male ☐Female

B. Required Immunizations and TB Skin Testing

This section must be completed by a medical practitioner. Alternatively, laboratory evidence of immunity or immunization records may be submitted to confirm immunization status.

Tuberculosis Skin Test

In order to comply with the Tuberculosis Surveillance Protocol for Ontario Hospitals, (developed by OHA/OMA) private companions are required to have a 2 step Mantoux test if he/she has:

a) Not had a positive TB skin Test result
b) Not had a TB Skin test within the past twelve months
c) Unknown TB status
d) Had a BCG vaccine and remains TB negative

Step 1: Date given_______________
Date read________________
mm Induration___________
Result ___________________

Step 2: Date given______________
Date read_________________
mm Induration_____________
Result ____________________

OR
Chest X-Ray Date:________
Result: __________________

Measles

☐ Laboratory evidence of immunity. Date: ________

☐ Not Immune/Indeterminate/ Unknown ***or***

1. MMR Vaccine Date: __________________
2. MMR Vaccine Date:___________________

Mumps

☐ Laboratory evidence of immunity. Date:____________

☐ Not Immune/Indeterminate/ Unknown ***or***

1. MMR Vaccine Date: ___________________
2. MMR Vaccine Date:___________________

Rubella	**Varicella/Zoster** (chickenpox)
☐ Laboratory evidence of immunity. Date:_________ ☐ Not Immune/Indeterminate/ Unknown ***or*** 1. MMR Vaccine Date: _______________ 2. MMR Vaccine Date:________________	☐ History of illness. Date: ________________ ☐ Not Immune/Indeterminate/ Unknown ***or*** Vaccine Date: ______________
Hepatitis B ☐ Laboratory evidence of immunity. Date: ________ ☐ Not Immune/Indeterminate/ Unknown or 1. Hep B Vaccine date: ____________ 2. Hep B Vaccine Date:_____________ 3. Hep B Vaccine date: _____________	**Tetanus/Diphtheria /Pertussis** Pertussis vaccination (dTap) once as an adult, Td every 10 years recommended ☐ dTap (Adacel) Date: ________________ ☐ Td Date: ________________
Section C completed by*:* I hereby declare this individual free of any communicable diseases/illnesses as per the information provided above. Health Care Professional: Nurse Practitioner/Physician ________________________ Date: ________________ Signature Stamp (required):	

C. Authorization

I hereby declare that this information is true and complete. I understand that all personal and medical information provided by me will be kept confidential as per the Baycrest Confidentiality of Health Information Policy.

Private Companion Signature: __________________________________ **Date:** _______________________

The personal information requested on this form is necessary to the proper administration of a lawfully authorized activity and, as applicable, is collected in accordance with subsection 38(2) of the Freedom of Information and Protection of Privacy Act (FIPPA), R.S.O. 1990, c.F. 31 as amended. The information provided will be used to protect the health, wellbeing and security of the Client and others. Questions about this collection may be directed to the Manager, Baycrest Private Companion Program 416-785-2500, 3560 Bathurst Street, Toronto, Ontario M6A 2E1.