LA TROBE UNIVERSITY

For information about this form contact your
Partnership Operations Coordinator

Immunisation & Health Record: Dentistry & Oral Health

About this form

The information collected in this form is used to offer you (the student) a clinical placement. La Trobe University will typically disclose this information to our health placement agencies. If you choose not to provide this information you may not be offered a placement. You may have the right to access the personal information we hold about you, subject to any exemptions in relevant laws, by contacting your Discipline Placement Officer.

La Trobe University respects the privacy of your personal information and complies with the Privacy and Data Protection Act 2014 and the Health Records Act 2001 when handling health information.

Note on blood-borne viruses

Blood-borne viruses (BBVs) are those viruses that are transmitted from the blood of one person to the blood of another person, particularly: **Hepatitis B Virus** (HBV), **Hepatitis C Virus** (HCV) & **Human Immunodeficiency Virus** (HIV).

For all your safety and the safety of clinical staff and patients, you must provide evidence (serology) of your HCV & HIV status for all Dentistry & Oral Health placements.

For more information please visit:
health.gov.au/resources/collections/cdna-national-guidelines-for-healthcare-workers-on-managing-bloodborne-viruses

Student declaration

I hereby request and give consent for the doctor/registered nurse identified in this form to complete this form in relation to my health information. I understand that all blood tests & vaccines will be privately billed as Medicare does not cover course-related tests.

Student number

Date of birth

D D M M Y Y

Full name

Signature

Doctor/Registered Nurse instructions

Thank you for your assistance preparing our students for their clinical placement. Please complete all sections of this form as proof of immunisation status for the conditions outlined. Students should be vaccinated in accordance with the recommendation of the current edition of The Australian Immunisation Handbook.

If this form is incomplete upon its submission date, please place a line through any incomplete items and sign the form so that it can be submitted. Evidence for any vaccines administered after the submission date should be provided as an immunisation record from the practice or clinic where it was received. Serology reports will need to be provided for any testing undertaken after that time.

Updates or amendments to this form after the signed date can not be accepted.

Please also attach all serological reports and immunisation records to the completed form.

Full name of Completing AHPRA Registered Doctor/Nurse

Qualifications/Registration number

Contact phone

Practice name

Suburb/locality of practice

1. Hepatitis B

Please provide either dates of a full course of vaccination **AND** a serology report **OR** core antibody results as evidence of a previous infection. Attach any supporting documentation to this form.

Vaccination course

Course type

X Adolescent course (2 doses) X Paediatric/adult course (3 doses)

1st dose date	**2nd dose date**	**3rd dose date**
D D M M Y Y	D D M M Y Y	D D M M Y Y
Brand / **Batch no.** (if known)	**Brand** / **Batch no.** (if known)	**Brand** / **Batch no.** (if known)

AND

Serology (Positive HBsAb test)

Date of test: D D M M Y Y

Result: HBsAb level (mIU/ml)

OR

Core antibody results (HBcAb test as evidence of a previous infection)

Date of test: D D M M Y Y

Result (Please mark either Immune or Not Immune with an X)

X Immune X Not Immune HBcAb level (mIU/ml)

Non-Responder to Primary Vaccination
Refer to non-responders to primary vaccination, Section 4.5.7 in the current edition of The Australian Immunisation Handbook. Persons who do not respond to the primary vaccination course and in whom chronic HBV infection has been excluded, should be offered further doses. A GP letter to be provided confirming further doses and serological testing as recommended for non-responders.

2. Varicella

Please provide either dates of a full course of vaccination **OR** a serology report.
Attach any supporting documentation to this form.

Vaccination course

1st dose date	**2nd dose date**
D D M M Y Y	D D M M Y Y
Brand / **Batch no.** (if known)	**Brand** / **Batch no.** (if known)

OR

Serology (Varicella IgG test)

Date of test: D D M M Y Y

Result (Please mark with an X)

X Positive X Negative

3. Diphtheria, Tetanus & Pertussis

Please provide date of a booster dTpa vaccine (**NOT** ADT). The vaccine must cover Diphtheria, Tetanus and Pertussis and must have been received within the last 10 years. Attach any supporting documentation to this form.

Vaccination course

Booster dose date: D D M M Y Y **Brand** **Batch no.** (if known)

4. Blood-borne viruses

Please provide a serology report.
Attach any supporting documentation to this form.

Hepatitis C serology

Date of test

D D M M Y Y

Result (Please mark with an X)

X Positive X Negative

HIV Serology (Human Immunodeficiency Virus)

Date of test

D D M M Y Y

Result (Please mark with an X)

X Positive X Negative

5. Measles, Mumps & Rubella

Please provide either a serology report for all three infections **OR** dates of a full course of vaccination.
Students attending a Paramedicine placement must provide serology. Attach any supporting documentation to this form.

Measles serology

Date of test

D D M M Y Y

Result (Please mark with an X)

X Positive X Negative

X Borderline

Mumps serology

Date of test

D D M M Y Y

Result (Please mark with an X)

X Positive X Negative

X Borderline

Rubella serology

Date of test

D D M M Y Y

Result (Please mark with an X)

X Positive X Negative

X Borderline

OR (Students attending a Paramedicine placement MUST provide serology)

Vaccination course

1st dose date

D D M M Y Y

Brand **Batch no.** (if known)

2nd dose date

D D M M Y Y

Brand **Batch no.** (if known)

Booster dose date (if required)

D D M M Y Y

Brand **Batch no.** (if known)

6. Tuberculosis

Please provide Quantiferon Gold test results. If your placement is within NSW, you may provide Mantoux test results instead.
Attach any supporting documentation to this form.

Test results

Test type (Please mark with an X)

X Quantiferon Gold

X Mantoux

Date of test

D D M M Y Y

Result (Please mark with an X)

X Positive X Negative

X Indeterminate

7. COVID-19

Please provide either dates of a full course of vaccination.
Attach any supporting documentation to this form.

1st dose date	2nd dose date	1st booster dose date	2nd booster dose date
D D M M Y Y	D D M M Y Y	D D M M Y Y	D D M M Y Y
Brand	**Brand**	**Brand**	**Brand**

Updates or amendments to the form after the signed date cannot be accepted

Doctor/Registered Nurse authorisation

Signature of Completing AHPRA Registered Doctor/Nurse

Date

D D M M Y Y