West Parry Sound Health Centre

PARRY SOUND, ONTARIO

VERIFICATION of IMMUNITY and COMMUNICABLE DISEASE STATUS

Part A- Immunity Confirmation

Tetanus	Rubella
Diphtheria	Hepatitis B
Polio	Varicella Zoster
Measles	(Chicken Pox)
Mumps	Influenza (Current Year)

I, (physician's name; print) ______________________________, verify that, to the best of my knowledge, the person named below is actively immune, either naturally or by vaccination, to those diseases listed in Part A above and is free from any of the communicable diseases listed in *Part A*.

Physician's Signature: ______________________________

Date: ____________________

Paramedic's name(print): ______________________________

Paramedic's Signature ______________________________

Date: ____________________

OR

Student, observer, etc. name(print): ______________________________

Student, observer, etc. signature: ______________________________

Date: ____________________

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99 Bowes Street, Parry Sound, Ontario P2A 2L8

TEL (705) 746-8440 FAX (705) 746-7510

Serving The Parry Sound District

must complete *Part B* on reverse

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SELF DECLARATION

Part B- Table of Communicable Diseases

Acquired Immunodeficiency Syndrome (Aids)	Leprosy
Amebiasis	Listeriousis
Anthrax	Malaria
Botulism	Measles
Campylobacter enteritis	Viral Meningitis
Cholera	Mumps
Cytomegalovirus Infection (congenital)	Opthalmia Neonatorum
Diphtheria	Parathyphoid Fever
Encephalitis (Primary Viral)	Pertussis (Whooping Cough)
Gastrointestesteritis	Plague
Giadiasis	Poliomyelitis (Acute)
Group A Streptococcal Disease (Invasive)	Psittacosis/Ornithosis
Haemophilus Influenza B Disease (Invasive)	Q Fever
Hemorrhagic Fevers including Ebola Virus Disease, Marburg Virus Disease, and other Viral Causes	
Viral Hepatitis including Hepatitis A, B, and C	Rabies
Influenza	Rubella
Lassa Fever	Salmonellosis
Legionellosis	Shingellosis
Tuberculosis	Tularemia
Typhoid Fever	Yellow Fever
Vertotoxin producing E. Coli Infections	Yersinosis

I, (name; print) ______________________, position i.e .paramedic, student, observer etc. ______________________ verify that, to the best of my knowledge, I am actively immune, either naturally or by vaccination, to those diseases listed in *Part B* above and is free from any of the communicable diseases listed in Part B.

Signature: ______________________

Date: ______________________

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