# ALGOMA DISTRICT PARAMEDIC SERVICES

## VACCINE PREVENTABLE DISEASES CERTIFICATE (PAGE 1 of 2)

**IMPORTANT NOTE:** In accordance with the *Ambulance Act of Ontario*, this form must be signed by a **physician** only.
**No other signature is acceptable.**

Name of Paramedic: ______________________ Date of birth: ______________ (yyyy-mm-dd)

| Disease | Schedule | Vaccination Status<br>(Please check one for each disease) |
|---|---|---|
| **Tetanus & Diphtheria** | **Primary series (3 doses) if unimmunized**<br><br>**Tetanus diphtheria (Td) booster doses every 10 years** | ◯ Vaccinated - Last dose date: ______________<br>◯ Medically contraindicated |
| **Polio** | **Primary series (3 doses) if previously unimmunized or unknown polio immunization history** | ◯ Vaccinated – Dose #3 date: ______________<br>◯ Medically contraindicated |
| **Pertussis** | **1 single dose of tetanus diphtheria acellular pertussis (Tdap) vaccine regardless of age if not previously received in adulthood** | ◯ Vaccinated - Dose #1 date: ______________<br>◯ Medically contraindicated |
| **Varicella (Chickenpox)** | **2 doses if no evidence of immunity** | ◯ Vaccinated – Dose #2 date: ______________<br>◯ Medically contraindicated<br>◯ Laboratory evidence of immunity<br>◯ Medically documented diagnosis or verification of history |

Printed name of physician ______________________ Date______________ (yyyy-mm-dd)

Physician's signature ______________________

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## VACCINE PREVENTABLE DISEASES CERTIFICATE (PAGE 2 of 2)

Name of Paramedic: ______________________ Date of birth: ______________ (yyyy-mm-dd)

| Disease | Schedule | Vaccination Status (Check one for each disease) |
|---|---|---|
| **Measles** | **2 doses if no evidence of immunity regardless of age** | ◯ Vaccinated - Dose #2 date: ______________<br>◯ Medically contraindicated<br>◯ Laboratory evidence of immunity |
| **Mumps** | **2 doses if no evidence of immunity** | ◯ Vaccinated - Dose #2 date: ______________<br>◯ Medically contraindicated<br>◯ Laboratory evidence of immunity |
| **Rubella** | **1 single dose if no evidence of immunity** | ◯ Vaccinated - Dose #1 date: ______________<br>◯ Medically contraindicated<br>◯ Laboratory evidence of immunity |
| **Hepatitis B** | **2-4 age appropriate doses and serologic testing within 1 to 6 months after completing the series** | ◯ Vaccinated - Last vaccination date: ______________ &<br>Serologic testing date: ______________<br>◯ Medically contraindicated<br>◯ Laboratory evidence of immunity |

Printed name of physician ______________________ Date______________ (yyyy-mm-dd)

Physician's signature ______________________