

# Fleming College

## COMMUNICABLE DISEASE DECLARATION

**This declaration must be signed by you in the presence of a Physician or Registered Nurse. The witness signature of the health care provider is also required.** By signing below, the student in the Paramedic program at Fleming College declares that, at this time, they are not under the care of a healthcare provider or being treated for any of the diseases listed in Table 1 - Part B of the Ambulance Service Communicable Disease Standards (see below) and is thus in compliance with these requirements.

<input type="checkbox"/> Acquired Immunodeficiency Syndrome (AIDS)	<input type="checkbox"/> Amebiasis
<input type="checkbox"/> Anthrax	<input type="checkbox"/> Botulism
<input type="checkbox"/> Campylobacter enteritis	<input type="checkbox"/> Chicken Pox (Varicella)
<input type="checkbox"/> Cholera	<input type="checkbox"/> Cytomegalovirus Infection (Congenital)
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Encephalitis (Primary Viral)
<input type="checkbox"/> Gastroenteritis	<input type="checkbox"/> Giardiasis
<input type="checkbox"/> Group A Streptococcal Disease (Invasive)	<input type="checkbox"/> Haemophilus Influenza B Disease (Invasive)
<input type="checkbox"/> Hemorrhagic Fevers including Ebola virus disease, Marburg Virus Disease, and Other Viral Causes	<input type="checkbox"/> Viral Hepatitis including Hepatitis A, B, and C
<input type="checkbox"/> Influenza	<input type="checkbox"/> Lassa Fever
<input type="checkbox"/> Legionellosis	<input type="checkbox"/> Leprosy
<input type="checkbox"/> Listeriosis	<input type="checkbox"/> Malaria
<input type="checkbox"/> Measles	<input type="checkbox"/> Viral Meningitis
<input type="checkbox"/> Meningococcal Meningitis	<input type="checkbox"/> Mumps
<input type="checkbox"/> Ophthalmia Neonatorum	<input type="checkbox"/> Parathyroid Fever
<input type="checkbox"/> Pertussis (Whooping Cough)	<input type="checkbox"/> Plague
<input type="checkbox"/> Poliomyelitis (Acute)	<input type="checkbox"/> Psittacosis / Ornithosis
<input type="checkbox"/> Q Fever	<input type="checkbox"/> Rabies
<input type="checkbox"/> Rubella	<input type="checkbox"/> Rubella (Congenital Syndrome)
<input type="checkbox"/> Salmonellosis	<input type="checkbox"/> Shigellosis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tularemia
<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Verotoxin producing E. Coli Infections
<input type="checkbox"/> Yellow Fever	<input type="checkbox"/> Yersiniosis

Student Name (please print): \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(must be signed in the presence of Physician or Registered Nurse)

Witness Name (please print): \_\_\_\_\_  
(must be Physician or Registered Nurse)

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_