NOSM UNIVERSITY | Undergraduate Medical Education

Learner Immunization Form

SECTION A: LEARNER AUTHORIZATION

Learner Last Name:(Please print) _____ Given Name: _____

Date of Birth:(yyyy-mm-dd)_____ Program Year: _____

I authorize the NOSM University (NOSM U) to use information collected on this form and disclose my personal health information to NOSM U teaching and administrative staff, officials of hospitals, health centers, and other organizations related to my NOSM U education, including but not limited to, clinical education experiences, community experiences, and electives as required.

I understand that the purpose for collecting, using, and disclosing this personal health information is to ensure compliance with health review and screening standards as required by section 4(2) of the Hospital Management Regulation made under the Public Hospitals Act (Ontario), other related legislation and regulations, and the Ontario Hospital Association/Ontario Medical Association Joint Communicable Disease Surveillance Protocol.

I acknowledge that to the best of my knowledge the personal health information provided in this form is completely accurate.

Learner Signature:_____ Date :(yyyy-mm-dd)_____

1. Learners who do not submit the appropriate immunizations records will be **refused, restricted or suspended** from clinical training until proper documentation is provided.
2. Learners are advised to retain a copy of this document for their personal records should a third party request this information.
3. The information collected on this form shall be used to ensure that health review and screening standards set out in the Public Hospitals Act and regulations and other related legislation and organizational policies are met so that learners may participate in clinical activities.
4. Any questions on the collection, use, or disclosure of your health information should be directed to records@nosm.ca

Learner Name:_____

SECTION B: HEALTH CARE PROFESSIONAL (HCP) VERIFICATION

Every HCP who completes any part of this form must complete this section. By signing below the HCP indicates that the information listed on this form is an accurate account of the learner's immune status as of the date shown.

Name of HCP (please print): _____ Profession: _____

Address: _____

Email address _____Telephone _____ Fax: _____

Signature _____Date (yyyy-mm-dd) _____

Please note the following:

1. **All** antibody titres/serology requested herein **must** be completed and attached as noted.
2. It is necessary for all New Undergraduate Learners to include copies of all laboratory reports.
3. If more than one HCP is involved, complete additional Section B on Page 6.
4. Section D **contains the requirements for NOSM U Learners**

SECTION C. EXCEPTIONS and CONTRAINDICATIONS and TESTING REQUIREMENTS

Is the resident **UNABLE** to meet any of the requirements listed in this document due to a medical or health condition?

☐ No, a medical or health condition is not present

☐ Yes, a medical or health condition is present; provide details below:

Details:_____

_____

_____

OR attach relevant information from a physician (i.e. unable to receive vaccines due to current use of biological agent)

☐ Relevant information from a physician attached

Affected learners **must** complete the ***Exceptions and Contraindications to Immunization and Testing Requirements, Self-Declaration Form (Appendix A)***

Learner Name:_____

SECTION D — LEARNER'S HEALTH INFORMATION

A. TUBERCULOSIS (TB)

1. **Past TB History**: Do any of the following apply?

   1) Documented positive tuberculin skin test (TST) or IGRA, blistering TST reaction? ☐ Yes ☐ No
   Date of positive TST/IGRA :(yyyy-mm-dd) _____ Results _____mm
   NOTE: Learners with Positive TST documented should **NOT** have further TST's

   2) Previous diagnosis and/or treatment for TB disease or TB infection ☐ No ☐ Yes
   If **"Yes**" applies to **any** of the **two** questions above, please complete **Appendix B "*Tuberculosis Awareness and Signs and Symptoms Self-Declaration Form"***
   If a learner has a positive TST documented above or any other positive TB history, the learner must submit a chest x-ray dated subsequent to the positive TST or any other positive TB history. Attach the report (or letter from TB physician specialist or TB clinic describing the film).

   The physician may use Appendix C for their report. Chest x-ray attached: ☐ Yes ☐ No
   A routine repeat or recent chest x-ray is not required unless there is a medical indication (e.g. symptoms of possible TB disease).

2. **TST:** Learners with a **negative** TB history, **documentation of a baseline two-step TST is required,** i.e. two separate tests, ideally 7-28 days apart but may be up to 12 months apart.
   A two-step TST given at any time in the past is acceptable and does **not** have to be repeated.
   All further TSTs, if required, can be single step TSTs.
   Two-step TST Documentation
   Step 1 (yyyy-mm-dd) _____Results (mm of duration) _____mm

   Step 2 (yyyy-mm-dd) _____Results (mm of duration) _____mm

   NOTE: A single step TST **is required** if your two-step TST was done **more than six months prior** to start of medical school.
   Note for International Learners - an IGRA test is acceptable for international **learners when TST is unavailable (this is rare). Attach IGRA documentation showing results (current within six months of medical school entry).**
   Note: Previous Bacillus Calmette–Guerin (BCG**)** vaccination is **not a contraindication to having a TST**

   Single-step TST if required above **:**(yyyy-mm-dd) _____Results (mm of duration) _____ mm
   TST's are no longer automatically required annually after entering medical school but **may** be required periodically depending on the learners TB exposure levels.
   Most recent TST **if not included above** (yyyy-mm-dd**)** _____Results (mm of duration**)** _____mm

3. **TB Exposures:** Please provide responses to the following **two** statements since your last negative Tuberculin skin test**.**

   ☐ No ☐ Yes Were you identified by occupational health or public health as having significant enough exposure to an individual diagnosed with infectious TB exposure to warrant testing?

   ☐ No ☐ Yes Have you had one or more of the following:
   ≥1 month of travel with very high-risk contact, particularly direct patient contact in a hospital or indoor setting, but possibly including work in prisons, homeless shelters, refugee camps or inner city slums.
   ≥3 months of travel to TB incidence country >400/100,000 population
   ≥6 months of travel to TB incidence country 200-399/100,000 population, ≥12 months of travel to TB incidence country – 100-199/100,000 population

Learner Name:_____

Note: If **"Yes**" applies to **one or both** statements, **complete Appendix B " Tuberculosis Awareness and *Signs and Symptoms Self-Declaration Form" and*** a ***repeat TST*** *is* ***encouraged.***

B. TETANUS, DIPHTHERIA (Td) and POLIO (Td)

Document **the last three** Tetanus/Diphtheria and Polio containing immunizations (minimum one month between the first two doses of a series; minimum six months between last two doses).The **last tetanus must be within the past 10 years**.

	Tetanus/diphtheria	Polio	HCP Initials
Last dose received			
Previous dose			
Previous dose			

C. PERTUSSIS (Whooping Cough)

Document a one-time pertussis vaccine (Tdap or Tdap-Polio) **given at age 18 years or older** (required even if not due for booster).Typically tetanus/diphtheria/acellular pertussis (Tdap) or tetanus/diphtheria acellular pertussis/polio(Tdap-polio).

Date of Tdap or Tdap-Polio immunization (yyyy-mm-dd) _____ Age received: _____

D. MEASLES, MUMPS, RUBELLA AND VARICELLA

ONE of the following items is required as evidence of immunity to measles:

- **TWO** doses of live measles-containing vaccine, given 28 or more days apart, with the first dose given on or after 12 months of age; **OR**
- Positive serology for measles antibodies (IgG); **OR**
- Laboratory evidence of measles infection

ONE of the following items is required as evidence of immunity to mumps:

TWO doses of live mumps-containing vaccine, given 28 or more days apart, with the first dose given on or after 12 months of age; **OR**

- Positive serology for mumps antibodies (IgG); **OR**
- Laboratory evidence of mumps infection.

ONE of the following items is required as evidence of immunity to rubella:

- **ONE** dose of live rubella-containing vaccine, given on or after 12 months of age; **OR**
- Positive serology for rubella antibodies (IgG) **OR**
- Laboratory evidence of rubella infection.

ONE of the following items is required as evidence of immunity to varicella:

- **TWO** doses of live varicella-containing vaccine, given ideally a minimum of six weeks apart (absolute minimum 28 days apart), with the first dose given on or after 12 months of age: **OR**
- Positive serology for varicella antibodies (IgG); **OR**
- Laboratory evidence of varicella infection.

IMMUNIZATIONS OR SEROLOGY

	Vaccine #1 Date (yyyy-mm-dd)	Vaccine #2 Date (yyyy-mm-dd)	OR	IgG (yyyy-mm-dd)	Laboratory Result	Interpretation (immune or not immune)	HCP Initial
Measles			**OR**				
Mumps			**OR**				
Rubella		**Not Required**	**OR**				
Varicella			**OR**				

Learner Name:_____

SEROLOGY Note: For students with no record of varicella immunizations, varicella serology must be tested. If results show non-immunity, then two doses of varicella vaccine are required.

E. HEPATITIS B

Documentation of a hepatitis B immunization series **is required** for all learners. Positive serology (anti-HBs) will not be accepted if there is an incomplete or absent record of immunization (exception: learners immune due to natural immunity, i.e. positive anti-HBs AND positive HBc or learners with hepatitis B infection do not require immunizations documented. Learners with an incomplete or undocumented series must get another series done and documented on the form below. Learners who are in the process of completing a series must complete **Appendix D "Hepatitis B non-Immune Self Declaration Form"**

1. Hepatitis B vaccine #1(yyyy-mm-dd) _____
2. Hepatitis B vaccine #2 (yyyy-mm-dd) _____ (2 dose series)
3. Hepatitis B vaccine #3 (yyyy-mm-dd) _____ (3 dose series)
4. Hepatitis B vaccine #4 (yyyy-mm-dd) _____(if required)
5. Hepatitis B vaccine #5 (yyyy-mm-dd) _____ (if required)
6. Hepatitis B vaccine #6 (yyyy-mm-dd) _____(if required)

Serology: Both anti-HBs (hepatitis B surface antibody) **and HBsAg** (hepatitis B surface antigen) are required.
Anti-HBs (test for immunity: For students who have immunity, only one positive anti-HBs result is required, which must be dated 28 or more days after the immunization series is completed. Repeat testing after this is not recommended. For students who are vaccine non-responders (i.e., student has received two complete, documented hepatitis B immunization series and post-immunization serology 1-6 months after the final dose has not demonstrated immunity), generally no further hepatitis B immunizations or serological testing are required; such student must complete the **Appendix D** "**Hepatitis B Not Immune, Self-Declaration Form"**

HBsAg (test for infection): Required for **all students**, including those who are believed to be immune to hepatitis B. Test must be conducted after the primary hepatitis B immunization series, OR if hepatitis B primary immunization series is still in process, test must be dated on or after medical school admission. Wait until 28 days after a hepatitis B immunization to avoid the possibility of a false-positive HBsAg result. Once the primary immunization series has been completed, repeat testing for HBsAg may be omitted from any additional testing conducted at the discretion of the HCP

Both tests are required for all learners	Date (yyyy-mm-dd)	Lab results	Interpretation	HCP Initials
Anti-HBs (antibody)			Immune ☐ Non Immune ☐	
HBsAg (antigen)			Infection ☐ No Infection ☐	

Learners who have infection with the Hepatitis B virus, human immunodeficiency virus (HIV), and or Hepatitis virus must familiarize themselves with the policies of the medical schools where they wish to apply.

It is recommended that learners consider receiving Hepatitis A immunization. Although nosocomial infections are rare, there is a potential for HAV transmission in the health care setting. It is also recommended that learners who rotate through the diagnostic microbiology laboratory should receive N.meningitidis vaccination (quadrivalent).

Learner Name:_____

F. HIV and HEPATITIS C TESTING (NOSM U Undergraduate Learners only)

All learners accepted into NOSM University's UME Program are required to undergo specific testing for human immunodeficiency virus (HIV-1/2 antigen/antibody)) and Hepatitis C virus (HCV antibodies). The test results must be discussed with a medical practitioner prior to entry into NOSM University. Documentation will be required once their acceptance into the program has been confirmed.

HIV-1/2 antigen/antibody: Date (yyyy-mm-dd) _____
(Results must be dated after Mar 01 of the year of entry into medical school and are valid for 4 years)

Undergraduate Learners must either complete section below or submit serology report. A medical practitioner must complete this section after reviewing the test results with the learner.

HIV-1/2 antigen/antibody – Date of most recent test (yyyy-mm-dd) _____

Results: ☐ Negative ☐ Positive (attach lab report once accepted into program)

HCV Antibodies - Date of most recent test (yyyy-mm-dd) _____

Results: ☐ Negative ☐ Positive (attach lab report once accepted into program)

HCP Name: _____Profession:_____

HCP Signature: _____Telephone:_____

Address: _____

Date/results of tests above reviewed with the learner: (yyyy-mm-dd) _____ to be read and completed by Undergraduate Learner

- ☐ I am aware of my status with respect to blood borne viruses, Hepatitis B, Hepatitis C and HIV
- ☐ I will self report any blood borne pathogen (BBP) infections with Hep B, Hep C and HIV to both home and elective schools

Signature of Learner:_____ Date: (yyyy-mm-dd) _____

G. INFLUENZA

Yearly Seasonal influenza (flu) vaccination is **required**. If the vaccine is not currently available, send documentation of the immunization once the vaccine becomes available (typically mid-October).

Current seasonal influenza vaccine (yyyy-mm-dd) _____

H. N-95 MASK FIT TEST

Have you ever been fit tested for an N-95 mask? Yes ☐ No ☐
If **yes**, please complete the following below and **attach your mask fit testing certificate**.

Date (yyy-mm-dd) _____N-95 Model _____ Size _____
Please Note: N-95 Mask Fit Testing **is required every two years**. If you have not had a N-95 mask fit test or your last N-95 mask fit test has expired, you will be fitted for one by NOSM U during the academic year.

Learner Name:_____

I. COVID-19 Vaccination

Have you been vaccinated for COVID-19? Yes ☐ No ☐

If **yes**, please complete the following.

Dose # 1 Date (yyyy/mm/dd) _____Brand _____
Dose # 2 Date (yyyy/mm/dd) _____Brand _____
Booster Date (yyyy/mm/dd) _____Brand _____
Booster Date (yyyy/mm/dd) _____Brand _____

SECTION B — HEALTH CARE PROFESSIONAL (HCP) VERIFICATION

Name of health care professional _____

Signature_____ Date (yyyy-mm-dd) _____

Clinic Name and Address _____

Clinic Telephone Number _____ Clinic Fax Number _____

Signature_____ Date (yyyy-mm-dd)_____

Learner Name:_____

APPENDIX A

Exceptions and Contraindications to Immunizations and Testing Self-Declaration Form

This form is to be completed by the learner

Note: If an appendix is not needed it does not need to be submitted with an application

This section applies only to residents who are **UNABLE** to meet any of the requirements listed in this document due to a medical or health condition (not including a contraindication to tuberculin testing)

My signature below indicates the following:

- I acknowledge that I may be inadequately protected against the following infectious disease(s) which are listed below:

  _____

- I acknowledge that in the event of a possible exposure, passive immunization or chemoprophylaxis may be offered to me for the infectious disease(s) listed above (if appropriate)

- I acknowledge that in the event of an outbreak of (one or more of) the infectious disease(s) listed above, I may be excluded from clinical duties for the duration of the outbreak.

- I acknowledge that I might be required to take additional precautions to prevent transmission such as wearing a surgical mask.

_____

Learner Name

_____

Signature

_____

Date (yyyy-mm-dd)

Learner Name:_____

APPENDIX B

Tuberculosis Awareness, and Signs and Symptoms Self-Declaration Form

This form is to be completed by the learner

Note: If an appendix is not needed it does not need to be submitted with an application

This section applies only to learners with **ONE OR MORE** of the following:

- A positive tuberculin skin test (TST) AND/OR
- A positive interferon gamma release assay (IGRA) blood test AND/OR
- Previous diagnosis and/or treatment for tuberculosis (TB) disease AND/OR
- Previous diagnosis and/or treatment for TB infection AND/OR
- Learners who may have had a significant exposure to infectious TB disease

I acknowledge the following:

1) Sometimes an individual with TB infection may progress to active (infectious) TB disease. I acknowledge that this can happen even for individuals who have normal chest X-rays, and for those who were successfully treated for active TB disease or latent tuberculosis infection in the past.

2) Possible TB disease includes one or more of the following persistent signs and symptoms:

    - Cough lasting three or more weeks
    - Hemoptysis (coughing up blood)
    - Shortness of breath
    - Chest pain
    - Fever
    - Chills
    - Night sweats
    - Unexplained or involuntary weight loss

3) I have a professional duty to obtain a prompt assessment from a clinician if I develop signs and symptoms of possible TB disease.

Do you have any of the symptoms in the above list?

☐ **No** I do not have any of the above symptoms at the present time

☐ **Yes** I have the following symptoms (attach correspondence from a clinician explaining the symptoms): _____

_____

_____

Learner Name_____

Signature _____

Date (yyyy-mm-dd) _____

Learner Name:_____

APPENDIX C

Explanation of Radiographic Findings

Note: If an appendix is not needed it does not need to be submitted with an application

This form must be completed by a physician who has assessed a learner with abnormalities of the lung or pleura noted on a chest X-ray with chest X-ray report attached (alternatively it is acceptable to attach a letter or form from a tuberculosis clinic or other specialized clinic covering the following items):

☐ Chest X-ray report attached

Name of learner: _____

Reason chest X-ray was obtained: _____

_____

_____

Explanation for abnormal findings: _____

_____

_____

Given the abnormal findings, does the learner pose a risk to others by participating in clinical duties?

_____

_____

_____

_____

Physician Name

_____

Signature

_____

Telephone

_____

Date (yyyy-mm-dd)

.

Learner Name:_____

APPENDIX D

Hepatitis B Vaccine Non-Immune Self-Declaration Form

This form to be completed by the learner

Note: If an appendix is not needed it does not need to be submitted with an application

This section applies only to students who either:

- are still in the process of completing a **documented** hepatitis B immunization series OR
- have received two complete, **documented** hepatitis B immunization series, and post- immunization serology has not demonstrated immunity (i.e., anti-HBs remains less than 10 IU/L)[2].

This appendix is not to be used to omit any required hepatitis B immunizations; students with an incomplete or undocumented series are to complete it, but still must have a series completed and documented on page 5 of this form.

For a student who has failed to respond to two immunization series, it is important to ensure (1) that each immunization series was documented, all doses were provided, and that minimal spacing between doses were respected; and (2) that post-immunization serology was conducted **between 28 days and six months** after the final dose of the series to be considered reliable. For such students generally no further pre-exposure hepatitis B immunizations or serological testing are required.

My signature below indicates the following:

- I acknowledge that there is no laboratory evidence that I am immune to Hepatitis B.
- I acknowledge that in the event of a possible exposure to hepatitis B (e.g., a percutaneous injury, human bite, or mucosal splash) I need to report the injury to my supervisor as soon after the incidence as possible as I may need passive immunization with hepatitis B immune globulin (efficacy decreases significantly if given more than 48 hours after the exposure).

_____

Learner Name

_____

Signature

_____

Date (yyyy-mm-dd)