MD Program
UNIVERSITY OF TORONTO

Year One Student Immunization Form

Information for Students
Immunization schedules vary considerably among Canadian provinces and other countries. Please **ensure your personal physician understands** that this form must be completed as indicated. Failure to comply may lead to repeat testing/immunization needles. Medical students who do not comply with the immunization policy may be excluded from clinical activities.

Information for Physicians
Students are required to be immunized against the following diseases before they enter the clinical setting. Proof of immunity is required for all persons carrying on activity in hospitals in Ontario under Regulation 965 of the Ontario Public Hospitals Act. Before completing this form, please read these instructions carefully.

Deadline: Please submit the completed form online, using ShareFile, by **August 4, 2017**.

Notice of Collection
The University of Toronto respects your privacy. The personal information provided on this form will be used by the administrative and student service offices at the Faculty of Medicine to administer your enrollment and program-related activities in the University of Toronto Doctor of Medicine Program.

The personal information provided on this form will only be used and protected in accordance with the Freedom of Information and Protection of Privacy Act. If you have any questions about this policy and/or ShareFile, please contact Janet Hunter, Director of Enrolment Services & Faculty Registrar, at 1 King's College Circle, Toronto, Ontario, M5S 1A8 or registrar.medicine@utoronto.ca.

SECTION 1 – STUDENT INFORMATION

University of Toronto Student Number:

Last Name:	**First Name:**

SECTION 2 – TUBERCULIN TEST

(a) Students must have a two-step Mantoux skin test between **June 1 and September 1** of this year unless there is a documented negative test during the preceding 12 months in which case a single-step test is sufficient

Test Dates:	Date (mm/dd/yyyy)	Results (mm of Redness & Induration)
Test #1	_____	_____
Test #2 (to be administered 1-3 weeks after the 1st test)	_____	_____
Previous BCG vaccination date:	_____	Previous Treatment for TB: ☐ Yes ☐ No

(b) Chest X-Ray required within the current calendar year if TB test results are positive (and/or known to be previously positive):

X-Ray Date (mm/dd/yyyy): _____ Result: _____

All students who test positive for TB must contact the Office of Health Professions Student Affairs (OHPSA) at ohpsa.admin@utoronto.ca

SECTION 3 – IMMUNIZATION

(a) HEPATITIS B Immunization

SECTION A: MUST COMPLETE ALL OF SECTION A

Date of 1st shot: _____ (mm/dd/yyyy) Date of 2nd shot: _____ (mm/dd/yyyy) Date of 3rd shot: _____ (mm/dd/yyyy)

Lab Evidence of Immunity
(**anti-HBs higher than 10 IU/L):** ☐ Immune (+) ☐ Non-immune (-) Date: _____ (mm/dd/yyyy)

SECTION 3 – IMMUNIZATION (continued)

(a) HEPATITIS B Immunization

SECTION B: IF NON-IMMUNE IN SECTION A, PLEASE PROVIDE: **Date(mm/dd/yyyy):**

Screening result for HBsAg: ☐ Positive (+) ☐ Negative (-) _____

If HBsAg positive,
must screen for HBeAg result: ☐ Positive (+) ☐ Negative (-) _____

SECTION C: IF IDENTIFIED AS NON-IMMUNE (SECTION A) & HBsAG NEGATIVE (SECTION B), A SECOND IMMUNIZATION SERIES IS REQUIRED. PLEASE PROVIDE DATES OF IMMUNIZATION AND SUBSEQUENT LAB EVIDENCE OF IMMUNITY TO THE UME ENROLMENT SERVICES OFFICE:

Date of 1st shot: _____ (mm/dd/yyyy) Date of 2nd shot: _____ (mm/dd/yyyy) Date of 3rd shot: _____ (mm/dd/yyyy)

Lab Evidence of Immunity (anti-HBs higher than 10 IU/L): ☐ Immune (+) ☐ Non-immune (-) Date: _____ (mm/dd/yyyy)

(b) HEPATITIS C: STUDENTS MUST RETAIN COPIES OF THEIR HEPATITIS C SEROLOGY RESULTS, AS WE MAY REQUEST THE ORIGINAL COPY.

Date of test: _____ (mm/dd/yyyy) Titre: ☐ Reactive ☐ Non-Reactive

(c) HUMAN IMMUNODEFICIENCY VIRUS (HIV): STUDENTS MUST RETAIN COPIES OF THEIR HIV SEROLOGY RESULTS, AS WE MAY REQUEST THE ORIGINAL COPY.

Date of test: _____ (mm/dd/yyyy) Titre: ☐ Reactive ☐ Non-Reactive

(d) MEASLES, MUMPS, RUBELLA & VARICELLA: STUDENTS MUST SHOW 2 DOSES OF MMRV VACCINE OR A POSITIVE BLOOD TEST TO EACH OF MMRV

Measles:
1st Immunization date: _____ (mm/dd/yyyy) 2nd Immunization date: _____ (mm/dd/yyyy) Or Titre date: _____ (mm/dd/yyyy) ☐ Reactive ☐ Non-Reactive

Mumps:
1st Immunization date: _____ (mm/dd/yyyy) 2nd Immunization date: _____ (mm/dd/yyyy) Or Titre date: _____ (mm/dd/yyyy) ☐ Reactive ☐ Non-Reactive

Rubella:
1st Immunization date: _____ (mm/dd/yyyy) 2nd Immunization date: _____ (mm/dd/yyyy) Or Titre date: _____ (mm/dd/yyyy) ☐ Reactive ☐ Non-Reactive

Varicella: *History of Varicella is not sufficient*

1st Immunization date: _____ (mm/dd/yyyy) 2nd Immunization date: _____ (mm/dd/yyyy) Or Titre date: _____ (mm/dd/yyyy) ☐ Reactive ☐ Non-Reactive

Note: Administration of a Live virus vaccine MAY interfere with TB skin testing, unless administered on the SAME day, or 4-6 weeks apart.

(e) DIPHTHERIA/TETANUS/ACELLULAR PERTUSIS (within the last 10 years): Date of Booster:
A single dose of Tetanus/Diphtheria/Acellular Pertussis (Tdap) should be given to all students who have not previously received an adolescent or adult dose of Tdap. ***It is not necessary to wait for the next diphtheria/tetanus booster to be due.***
_____ (mm/dd/yyyy)

(d) POLIO (primary vaccination series required): _____ (mm/dd/yyyy)

SECTION 4 – STUDENT AUTHORIZATION

I give my consent that the information on this form may be shared with university/hospital teaching and administrative staff in appropriate cases.

Signature of student: _____ **Date (mm/dd/yyyy):** _____

SECTION 5 – CLINIC/HEALTH CENTRE AUTHORIZATION

I certify that the above information is complete and accurate:

_____

(name, address, and phone number of clinic/health care centre/hospital where the form was completed)

Signature of health care professional: _____ **Date (mm/dd/yyyy):** _____