MD Program
UNIVERSITY OF TORONTO

Year One Student Immunization Form

Deadline: Please submit the completed form online, using **ShareFile**, by **July 31, 2024**.

Completing this Form: Students can print this form and have it completed by an appropriate health care professional (HCP), i.e., a nurse, physician, physician assistant, or pharmacist; the item(s) documented must be within the HCP's scope of practice. Students must not complete any part of this form with the exception of Section A and Appendices A, B and D; the remainder of the form is to be completed by the HCP. Close family members and postgraduate residents must not complete the form. Submit the completed form and any attachments according to the instructions on the MD Program's Registration Requirements & Requests page.

Guidelines Document: For additional details, refer to the COFM Immunization Policy.

SECTION A: STUDENT DECLARATION

All students must abide by the following declaration:

1. I understand that the personal health information provided in this form shall be kept confidential and will be used by the administrative and student service offices at the Temerty Faculty of Medicine to:
    a. administer my enrollment and program-related activities in the University of Toronto Doctor of Medicine Program, and
    b. ensure that I meet its health standards or the ones of the relevant health authorities or clinical sites.
2. I give my consent that the information on this form may be shared with university/hospital teaching and administrative staff in appropriate cases.
3. I acknowledge that to the best of my knowledge the personal health information provided in this form is completely accurate.
4. I have not completed any part of this form myself, with the exceptions of this section and (if applicable) Appendix A. An appropriate health care professional must complete all other sections and appendices.

My signature below indicates that I have read, understood, and agree to the above four items.

Last Name: _____	**Given Name(s):** _____
Student Number: _____	
Signature: _____	**Date (yyyy-mm-dd):** _____

SECTION B: HEALTH CARE PROFESSIONAL (HCP) INFORMATION

Every HCP who completes any part of this form must complete this section. HCP initials verify the HCP has either provided the service or the HCP has reviewed the student's adequately documented records. The item(s) documented must be within the HCP's scope of practice. Dates are to be in the format "yyyy-mm-dd". HCPs signing below acknowledge they are not signing a form a student has previously completed.

HCP #1

Name: _____ Profession: _____ Initials: _____

Address: _____

Tel: _____ Fax: _____

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

HCP #2

Name: _____ Profession: _____ Initials: _____

Address: _____

Tel: _____ Fax: _____

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

SECTION C: EXCEPTIONS AND CONTRAINDICATIONS TO IMMUNIZATION AND TESTING REQUIREMENTS

Is the student 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 OR attach relevant information from a physician (for example: "unable to receive live vaccines due to current use of a biological agent"). Affected students also must complete the *Exceptions and Contraindications to Immunization and Testing Requirements, Self-Declaration Form* (Appendix A).

Details:

- ☐ Relevant information from a physician attached.

SECTION D: TUBERCULIN TEST

1. **TB History:** Does the student have ANY of the following: a previous history of a positive tuberculin skin test (TST); a clear history of blistering TST reaction; a positive interferon gamma release assay (IGRA) test; a previous diagnosis of TB disease or TB infection; a history of treatment for TB disease or infection?
   - ☐ **Yes** – The student should not have a repeat TST. Go to *Tuberculosis Awareness, and Signs and Symptoms Self-Declaration Form* (Appendix B).
   - ☐ **No** – Proceed to Questions 2-4.

SECTION D: TUBERCULIN TEST

2. TST: For students without a positive TB history, documentation of a two-step TST is required (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; a two-step TST does not need to be repeated. Previous Bacillus Calmette–Guérin (BCG) vaccination is not a contraindication to having a TST. A TST can be given either before, the same day as, or at least 28 days after a live virus vaccine. An IGRA test is acceptable for international students when a TST is unavailable (this is rare). Attach IGRA documentation showing results current within six months of medical school entry.

Two-Step TST:

Step	Date Given* (yyyy-mm-dd)	Date Read* (yyyy-mm-dd)	Millimeters of Induration	Interpretation according to Canadian TB Standards[1]	HCP Initials
1					
2					

* If only a single date is available this is acceptable so long as appropriate spacing between TSTs and/or vaccines can be verified.

Most Recent TST (not including TSTs documented above): If the two-step TST was done more than six months prior to medical school entry, the student needs to have a single TST performed.

Date Given (yyyy-mm-dd)	Date Read (yyyy-mm-dd)	Millimeters of Induration	Interpretation according to Canadian TB Standards[1]	HCP Initials

Students found to have a positive TST also must complete and attach the *Tuberculosis Awareness, and Signs and Symptoms Self-Declaration Form* **(**Appendix B**).**

3. Provide responses to the following three statements regarding the student's experiences since admission to medical school:

- ☐ **Yes** ☐ **No** The student had significant[1] exposure to an individual diagnosed with infectious TB disease
- ☐ **Yes** ☐ **No** The student spent time in a clinical setting with high risk of exposure to infectious TB (e.g., international electives)
- ☐ **Yes** ☐ **No** The student lived or worked in an area of the world with high TB incidence[2]

If "**Yes**" applies to the student on one or more of these three statements, the student must complete the *Tuberculosis Awareness, and Signs and Symptoms Self-Declaration Form* **(**Appendix B**).**

4. Chest X-ray: If a student has a positive TST documented or any other positive TB history, the student must have a chest X ray dated subsequent to the positive TST or other positive TB history. A routine repeat or recent chest X-ray is not required unless there is a medical indication (e.g., symptoms of possible TB disease).

Chest X-ray required?

- ☐ **Yes** – Attach the report (or letter from a TB physician specialist or TB clinic report describing the film)
- ☐ **No**

If any abnormalities of the lung or pleura are noted on the chest X-ray report, documentation from a physician is required. Physicians may use the *Explanation of Radiographic Findings* (Appendix C) form or attach a letter to explain the findings.

[1] Whether an exposure was significant and requires follow-up testing should be determined by the occupational health unit in the facility, or public health unit in the local jurisdiction of the exposure.

[2] For a definition of high incidence countries refer to "*AFMC Student Portal Immunization and Testing Guidelines*" (https://afmcstudentportal.ca/immunization).

SECTION E: HEPATITIS B

Immunizations: Documentation of a hepatitis B immunization series is required for all students. Positive serology (anti-HBs) will not be accepted if there is an incomplete or absent record of immunization (exception: students immune due to natural immunity, i.e., positive anti-HBs AND positive anti-HBc, or students with hepatitis B infection do not require immunizations documented). Students with an incomplete documented series must complete *Hepatitis B Not Immune, Self-Declaration Form* (Appendix D).

	Date (yyyy-mm-dd)	Type of vaccine used *	HCP Initials
Vaccine 1:			
Vaccine 2:			
Vaccine 3 (If required):			
Vaccine 4 (If required):			
Vaccine 5 (If required):			
Vaccine 6 (If required):			

* If information on the name of the vaccine given is no longer available, simply document the date of the immunization.

Serology: Both anti-HBs (hepatitis B surface antibody) and HBsAg (hepatitis B surface antigen) are required**.**

Anti-HBs (test for immunity): For students who are able to achieve 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. If the student is not immune, only the most recent negative post-immunization anti-HBs is required; such students must also complete the form *Hepatitis B Not Immune, Self-Declaration Form* (Appendix D). 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.

HBsAg (test for infection): Required for all students, including those who are believed to be immune to hepatitis B. Test must be conducted on or after the time of the assessment for hepatitis B immunity, 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 required for all students:	Date (yyyy-mm-dd)	Laboratory result	Interpretation	HCP Initials
anti-HBs (antibody)			☐ Immune ☐ Non-immune	
HBsAg (antigen)			☐ Infection ☐ No infection	

Note: If identified as non-immune and HBsAG negative, a second immunization series is required

SECTION F: MEASLES, MUMPS, RUBELLA & VARICELLA:

General Requirements:

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

1. 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
2. Positive serology for measles antibodies (IgG); OR
3. Laboratory evidence of measles infection.

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

1. 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
2. Positive serology for mumps antibodies (IgG); OR
3. Laboratory evidence of mumps infection.

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

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

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

1. 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
2. Positive serology for varicella antibodies (IgG); OR
3. Laboratory evidence of varicella infection.

Immunizations:

	Vaccine 1, Date (yyyy-mm-dd)	Vaccine 2, Date (yyyy-mm-dd)	HCP Initials
Measles Vaccine			
Mumps Vaccine			
Rubella Vaccine		NOT REQUIRED	
Varicella Vaccine			

Serology: For students with no record of measles, mumps or rubella immunizations a preferred approach is to immunize without checking pre-immunization serology (regardless of age), although testing serology (IgG) is an acceptable alternative to immunization. For students with no record of varicella immunizations, varicella serology must be tested. Post-immunization serology testing for measles, mumps, rubella, or varicella should NOT be done once immunization requirements have been met.

	Test Date (yyyy-mm-dd)	Laboratory Result	Interpretation (Immune or non-immune)	HCP Initials
Measles IgG				
Mumps IgG				
Rubella IgG				
Varicella IgG				

Laboratory Evidence of Infection: *(Note: Having this evidence is uncommon). Submit the laboratory report with this form if a student has laboratory evidence of actual infection (e.g., isolation of virus; detection of deoxyribonucleic acid or ribonucleic acid; seroconversion) to measles, mumps, rubella, or varicella. This evidence will meet the requirements of immunity for the item.*

☐ **Laboratory evidence of infection attached.**

SECTION G: PERTUSIS

Document a one-time pertussis vaccine (Tdap or Tdap-Polio) given at age 18 years or older (required even if not due for a booster):

Date (yyyy-mm-dd)	Type of vaccine used*	Age received (must be 18 years or older)	HCP Initials

* The precise type of vaccine used must be known; if this information is no longer available, repeat the immunization. Typically, tetanus/diphtheria/acellular pertussis (Tdap) or tetanus/diphtheria/acellular pertussis/polio (Tdap-Polio) will be used.

SECTION H: TETANUS, DIPHTHERIA, AND POLIO

Document the last three tetanus/diphtheria and polio containing immunizations (minimum one month between first two doses of a series; minimum six months between last two doses; last tetanus/diphtheria immunization must be within the past ten years). Serology is not accepted for tetanus, diphtheria, and polio.

	Tetanus/diphtheria, Date (yyyy-mm-dd)	Polio, Date (yyyy-mm-dd)	HCP Initials
Last dose received:			
Previous dose:			
Previous dose:			

SECTION I: NOVEL CORONAVIRUS DISEASE 2019 (COVID-19)

In addition to the other required vaccinations, we are requiring information on COVID-19 vaccination status. **Please submit a proof of your vaccination against COVID-19 (your vaccination receipt which is issued to you at the time of your vaccination) along with this immunization form as one single document.**

The approved vaccines include:

- 2 Doses of the mRNA vaccines(Pfizer-BioNTech/Comirnaty or Moderna (Spikevax) or 2 Doses of AstraZeneca (VaxZevria)
- 2 Doses of the one of the vaccines that are approved by Health Canada **PLUS** 1 of mRNA vaccines listed above
- 1 Dose of Janssen/Janssen

This is consistent with the COFM Guidelines, in the interests of preventing and reducing the transmission of COVID-19 at a hospital or other placement site, and to satisfy possible requirements for COVID-19 vaccination status information by specific hospitals or other placement sites.

Exemption Request: If you are unable to satisfy this requirement, please contact Hana Lee, Director, Enrolment Services & Faculty Registrar, at 1 King's College Circle, Toronto, Ontario, M5S 1A8 or registrar.medicine@utoronto.ca.

SECTION J: INFLUENZA

An up-to-date seasonal influenza immunization is required. If vaccine is not currently available, document the immunization once vaccine becomes available (typically mid-October) and resubmit this updated form online.

Current seasonal influenza vaccine date (yyyy-mm-dd): _____ HCP Initials: _____

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Appendix A: Exceptions and Contraindications to Immunizations and Testing, Self-Declaration Form

Notes:
1. If this appendix is not needed, please do not submit this page with the immunization form.
2. For an exemption from the COVID-19 vaccination, you will need to complete a separate form.

This box is to be completed by the student.

This section applies only to students 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 skin testing).

My signature below indicates the following:

- ✓ I acknowledge that I may be inadequately protected against the following infectious disease(s):

  _____

- ✓ 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.

Last Name: _____ (Please print)	Given Name(s): _____ (Please print)
Signature: _____	Date (yyyy-mm-dd): _____

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Appendix B: Tuberculosis Awareness, and Signs and Symptoms Self-Declaration Form

Note: If this appendix is not needed, please do not submit this page with the immunization form.

This box is to be completed by the student.

This section applies only to students 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
- Students who may have had a significant exposure to infectious TB disease (defined in **Section C**)

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.
(Also attach correspondence from a clinician explaining the symptoms):

_____

_____

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

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

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Appendix C: Explanation of Radiographic Findings

Note: If this appendix is not needed, please do not submit this page with the immunization form.

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

☐ ***Chest X-ray report attached.***

Name of student: _____

Reason chest X-ray was obtained:

_____

_____

Explanation for abnormal findings:

_____

_____

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

_____

_____

Physician name: _____

Address: _____ Tel: _____

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

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Appendix D: Hepatitis B Non-Immune Self-Declaration Form

Note: If this appendix is not needed, please do not submit this page with the immunization form.

This box is to be completed by the student.

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).

  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).

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

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