



## Communicable Disease Screening Form – Visiting Medical Elective Students

Please return to Undergraduate Medical Education, 68 Barrie Street, Kingston, ON K7L 3N6  
Phone: 613-533-2542, Fax: 613-533-3190

Student Name: \_\_\_\_\_

**Students are required to be immunized against certain diseases before they enter the clinical setting. The background rationale and operational aspects governing this process is outlined in the Immunization and Communicable Disease Policy ([http://meds.queensu.ca/assets/ug\\_-\\_immunization\\_\\_comm.\\_dis.\\_policy\\_-\\_final.pdf](http://meds.queensu.ca/assets/ug_-_immunization__comm._dis._policy_-_final.pdf)) and follows from principles established by the Public Hospitals Act, Section 4.2, Ontario Regulations 204/06 and the guidelines of Council of Ontario Faculties of Medicine (COFM). The information collected will be used to ensure that these standards are met in order for students to safely participate in clinical activities.**

**Please ensure that this form is completed by a health care professional as per the instructions. Failure to comply with the Communicable Disease Policy may result in modification of your elective.**

**Please review Communicable Disease Screening Protocol prior to the completion of this form.**

### HEPATITIS B

Initial vaccination series: Dose 1 (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_  
Dose 2 (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_  
Dose 3 (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_

Date of anti-HBs antibody titer (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_

- Reactive/Immune (+); titer \_\_\_\_\_
- Non-reactive/not immune (-)

Only to be completed if anti-HBs antibody titer is non-reactive:

Date of Hepatitis B surface antigen (HBsAg) test (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_

- Reactive (+)
- Non-reactive (-)

Students who are negative for anti-HBs despite one Hepatitis B vaccine series and who are HBsAg negative (i.e. are non-responders to the first series of Hepatitis B vaccine) are required to have a second series of Hepatitis B vaccination (Twinrix product preferred) and submit the results of a second anti-HBs, one month after the completion of the second series of vaccination.

Repeat vaccination series: Dose 1 (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_  
Dose 2 (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_  
Dose 3 (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_

Repeat anti-HBs antibody (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_

- Reactive/Immune (+)
- Non-reactive/not immune (-)



**Students not responding to the 2<sup>nd</sup> round of vaccine will repeat the HBsAg test and submit results – if negative the student will receive a 3<sup>rd</sup> round vaccine with intradermal vaccine. Non-responders to the third round of the Hepatitis B vaccine will be referred to the Communicable Disease Advisory Group.**

**TUBERCULOSIS**

*Please select one of the options for TB screening.*

*Note: 5 mm or more of induration is considered positive for those infected with HIV, those who have been in recent close contact with active TB or those who have chest x-ray indicating healed TB. 10 mm or more of induration is considered positive for all others.*

**Option #1 – 2-Step Tuberculin Skin Test (TST) Required**

*Provide documentation of previous 2-step TST within last 12 months, if not available, do 2-step TST.*

Step One Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ mm induration: \_\_\_\_\_

Step Two Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ mm induration: \_\_\_\_\_

(Step Two test should take place within 1-3 weeks of Step One if step one was negative)

**Option #2**

*If a 2-step TST was completed within the last 12 months from current date, provide this documentation along with a follow up single step TST.*

Step One Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ mm induration: \_\_\_\_\_

**Option #3**

If either of the above TST is positive, the student will require a chest x-ray.

Date of x-ray: \_\_\_/\_\_\_/\_\_\_ Result of x-ray: \_\_\_\_\_  
(mm/dd/yyyy)

**MEASLES/MUMPS/RUBELLA**

Students must provide evidence of **two** doses of measles vaccine or serological evidence of immunity.

**Measles**

Dose #1: (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ Record attached – please circle (yes) (no)

Dose #2: (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

Students must provide evidence of **one** dose of mumps and rubella vaccine or serological evidence of immunity.

**Mumps**

Date of vaccination (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ Record attached – please circle (yes) (no)

**Rubella**

Date of vaccination (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ Record attached – please circle (yes) (no)

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### **TETANUS/DIPHTHERIA**

*Students must provide proof of receipt of primary series of vaccines or booster received within the last 10 years for tetanus and diphtheria.*

#### **Primary Series or Booster received within last 10 years:**

Date of booster : \_\_\_/\_\_\_/\_\_\_\_\_  
(mm/dd/yyyy)

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### **POLIO**

Students are required to provide documentation of having received a complete primary series of polio vaccine. Polio vaccine series consists of 5 doses for children up to 6 years old, or 3 doses if primary series started after age 7 (adult dose). Please attach record of vaccine.

Date: \_\_\_/\_\_\_/\_\_\_\_\_  
(mm/dd/yyyy)      Date: \_\_\_/\_\_\_/\_\_\_\_\_  
(mm/dd/yyyy)      Date: \_\_\_/\_\_\_/\_\_\_\_\_  
(mm/dd/yyyy)

Date: \_\_\_/\_\_\_/\_\_\_\_\_  
(mm/dd/yyyy)      Date: \_\_\_/\_\_\_/\_\_\_\_\_  
(mm/dd/yyyy)

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### **VARICELLA (Chicken Pox)**

*Students are required to supply the serological status of immunity. Please attach serology.*

Date of test (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_  
      Reactive (+)

     Non-reactive (-)

*If non-immune, student must receive immunization and submit this documentation to UGME office. Non-immune students who have a contraindication to receiving the varicella vaccine should have received medical counseling on the subject prior to their elective at Queen's University.*

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### **INFLUENZA**

Each student is required to obtain an annual influenza immunization. The Ontario government provides the influenza vaccine free to all citizens during the flu season. Students will be required to follow Public Health guidelines put forward for health care professionals.

Date: \_\_\_/\_\_\_/\_\_\_\_\_  
(mm/dd/yyyy)



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### HEPATITIS C

Students must provide documentation of their Hepatitis C serology within the last 3 months at the time of completing this form. Please attach serology.

Date of test (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_

- Reactive (+)  
 Non-reactive (-)

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### HIV

Students must provide documentation of their HIV serology within the last 3 months at the time of completing this form. Please attach serology.

Date of test (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_\_

- Reactive (+)  
 Non-reactive (-)

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### Student Authorization:

I give my consent that the information on this form may be shared as required with the university and hospital teaching and administrative staff.

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

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### Part 7 – Health Professional Information (i.e. physician, nurse, etc.)

**Any incomplete sections should be voided & initialed**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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