



Communicable Disease Screening Form – 1st Year Students

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

Student Name: _____ Student #: _____

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) 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 lead to limited participation in clinical aspects of the MD program.

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 have a positive result for the HBsAg test will be informed of the results and referred to the Director, Student Affairs, an appropriate specialist, and for career counseling. They will also need HBeAg, anti-HBe, and Hepatitis B DNA levels.

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 4th dose of Hepatitis B vaccination and submit the results of a second anti-HBs (done at one month after 4th dose).

Repeat vaccination series: Dose 4 (mm/dd/yyyy): ___/___/_____

Repeat anti-HBs antibody (mm/dd/yyyy): ___/___/_____

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

Students not responding to the 4th dose can be offered a subsequent round of vaccination with intradermal vaccine as soon as possible when it has been determined that there was no response to the fourth intramuscular dose.

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 (-)

Non-responders to the Hepatitis B vaccine will be referred to the Director, Student Affairs and an appropriate specialist for assessment and counseling. Non-responders will be referred to an ID specialist for alternative vaccination techniques. This may result in a modified curriculum.

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 and referral to the Tuberculosis Clinic at Kingston General Hospital.

Chest x-ray required (yes) (no)

Date of x-ray: ___/___/_____ Result of x-ray: _____
(mm/dd/yyyy)

MEASLES/MUMPS/RUBELLA

Students must provide evidence of **two** doses of Trivalent (MMR) measles, mumps and rubella vaccine or serological evidence of immunity.

Measles, Mumps, Rubella

Dose #1: (mm/dd/yyyy): ___/___/_____

Record attached – please circle (yes) (no)

Dose #2: (mm/dd/yyyy): ___/___/_____

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. Students are responsible for ensuring that these boosters remain up to date after medical school admittance.

Primary Series or Booster received within last 10 years:

Date of booster : ___/___/_____
(mm/dd/yyyy)

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)

VARICELLA (Chicken Pox)

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

Date of test (mm/dd/yyyy): ___/___/_____
Date of test (mm/dd/yyyy): ___/___/_____
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 must inform the UGME Office upon enrollment and will be referred to the Director, Student Affairs.

PERTUSSIS

Students should be aware that the acellular pertussis vaccine is not publicly funded in Ontario. Despite this, students are strongly encouraged to receive one dose of acellular pertussis-containing vaccine or provide thereof.

Date: ___/___/_____
(mm/dd/yyyy)

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. This immunization must be received by December 1st each academic year and documentation forwarded to the UGME Office by the student.

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): ___/___/_____
Date of test (mm/dd/yyyy): ___/___/_____
Date of test (mm/dd/yyyy): ___/___/_____

- Reactive (+)
 Non-reactive (-)



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 (-)

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. ** Please retain a copy for your records.*

Signature: _____ Date: _____

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

Any incomplete sections should be voided & initialed

Name: _____

Address: _____

Telephone: _____ Fax: _____

Signature: _____ Date: _____

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