Communicable Disease Screening Form – 1st Year Students

Student Name:_____DOB_____Student #:_____Graduating year:_____

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.

This form must be 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.
This highly sensitive information will be held in strict confidence and only disclosed as needed to staff and faculty with the consent of the student involved.

PART A: STUDENT AUTHORIZATION

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

Signature: _____ Date: _____

PART B: HEALTH PROFESSIONAL INFORMATION AND DESIGNATION

Health Professional Information (i.e. Physician, Nurse, etc.)

Any incomplete sections should be voided & initialed

Name & Designation:_____
(Please print)

Address: _____

Telephone: _____ Fax: _____

Signature: _____ Date: _____

** Please retain a copy for your records.*

PART C: BLOOD BORNE DISEASES

HEPATITIS B

Students must provide documentation of their Hepatitis B serology at the time of completing this form. ***Please attach serology***.

Date of Hepatitis B surface antigen (HBsAg) serology (yyyy/mm/dd): _____/_____/_____

*Reactive ☐ Non-reactive ☐

Date of Hepatitis B surface antibody (HBsAb) serology (yyyy/mm/dd) _____/___/____

Reactive ☐ (numerical result) _____ Non-reactive ☐

Adequate serological reponse is the equivalent of ≥10 international Units (IU) of antibody to HBsAg per litre when tested by the radioimmunoassay (RIA) method.

Please provide dates of series vaccination:

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

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

Dose #3 (yyyy/mm/dd):___/___/____

***If inadequate serological response (<10mmol), a second series of vaccination is required*

Dose #4 (yyyy/mm/dd):___/___/____

Dose #5(yyyy/mm/dd):___/___/____

Dose #6 (yyyy/mm/dd):___/___/____

Date of Hepatitis B surface antibody (HBsAb) serology (yyyy/mm/dd) _____/___/____

Reactive ☐ (numerical result) _____ ***Non-reactive ☐

**Students who have a positive result for the HBsAg test will be 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).*

****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.*

HEPATITIS C

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

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

HIV

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

Date of test (yyyy/mm/dd): _____/___/____ Reactive ☐ Non-reactive ☐

PART D: COMMUNICABLE DISEASES

TUBERCULOSIS

Health care workers whose Tuberculin Skin Test (TST) status is unknown, and those previously identified as tuberculin negative, require a baseline two step TST ***(the second test should be performed 1 to 4 weeks later)*** *with PPD/5TU, unless they have:*

- *Documented results of a prior two step test OR*
- *Documentation of a negative TST within the last 12 months,*

in which case a single step test may be given.
(Note: Induration of 5 mm or more is considered positive for those infected with HIV, those who have been in contact with active TB within the past two years or those who have chest x-ray indicating healed TB (and not previously treated), immunosuppressive therapy, end-stage renal disease. Induration of 10 mm or more is considered positive for all others.)

Provide documentation of previous 2-step TST (if no documentation, do a 2 step now)

Step One Date (yyyy/mm/dd): ___/___/_____ mm induration: _____

Step Two Date (yyyy/mm/dd): ___/___/_____ mm induration: _____

Provide documentation of a negative TST* within last 12 months

Step One Date (yyyy/mm/dd): ___/___/_____ mm induration: _____

If either of the above TST is positive, the student will require a chest x-ray and referral to a Tuberculosis Clinic.* ***A copy of the chest x ray must be attached as well as report from the TB clinic indicating outcome/follow up.*

Chest x-ray required (yes) (no) Date of x-ray: _____/_____/_____ Result of x-ray: _____
(yyyy/mm/dd)

NOTE: The TST remains the standard for use in OHS in hospitals. *Blood tests which measure interferon-γ (interferon-γ release assays, IGRAs) can be used to diagnose latent tuberculosis infection (LTBI) particularly in persons who have received Bacille Calmette-Guerin (BCG) vaccine. Results may be difficult to interpret, particularly if BCG was administered after one year of age, or repeated. IGRAs should be used in consultation with a physician with experience and expertise in diagnosis and management of TB.*

MEASLES/MUMPS/RUBELLA

Students must provide documentation of receipt of 2 doses of MMR vaccine on or after the first birthday, with doses given at least four weeks apart. If this documentation is not available, the student must make every effort to receive 2 doses of MMR vaccine. Alternatively, testing serology is an acceptable alternative to immunization but less preferred. Should serology be tested, please provide a copy of the serology.
Please attach copy of record of receipt of MMR vaccines.

MMR #1 Date: (yyyy/mm/dd) _____/___/____

MMR #2 Date: (yyyy/mm/dd) _____/___/____

VARICELLA (Chicken Pox)

Students must supply evidence of immunity, which includes: documentation of receipt of 2 doses of varicella-containing vaccine, given six weeks or more apart, with the first dose given on or after 12 months of age.

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

Date (yyyy/mm/dd): _____/___/____ (Serologic testing for immunity after immunization is not recommended.)

OR

Serological evidence of immunity. **Please attach serology.**

Date of test (yyyy/mm/dd): _____/___/____ Reactive ☐ *Non-reactive ☐

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.

POLIO

Students are required to provide documentation of having received a complete primary series of poliomyelitis vaccine (4 doses for children up to 6 years old, or 3 doses if primary series started after age 7). Please attach record of immunization.

If received primary series in infancy:

Dose #1 (yyyy/mm/dd) ____/_____/_____

Dose # 2 (yyyy/mm/dd) _____/____/_____

Dose # 3 (yyyy/mm/dd) _____/___/_____

Dose # 4 (yyyy/mm/dd) _____/____/_____

*Dose # 5 (yyyy/mm/dd) _____/____/_____

**Adults previously immunized with polio vaccine who are at increased risk of exposure (health care workers who have close contact with patients who might be excreting wild type or vaccine type poliovirus) should receive a single lifetime booster dose of IPV containing vaccine*.

If not immunized or no documentation:

Adults at increased risk for polio who have not been immunized and only need polio protection, should receive two doses of IPV containing vaccine given 4-8 weeks apart, followed by a third dose 6-12 months apart, after the second dose.

Dose #1 (yyyy/mm/dd) ____/_____/_____

Dose # 2 (yyyy/mm/dd) _____/____/_____

Dose # 3 (yyyy/mm/dd) _____/___/_____

TETANTUS/DIPHTHERIA/PERTUSSIS

Students must provide proof of receipt of primary series of vaccine or booster received within last 10 years for tetanus and diphtheria. Students are responsible for ensuring that these boosters remain up to date after medical school admittance.

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

Students are also strongly encouraged to receive one adult-dose (18 years of age and older) of **acellular pertussis-containing vaccine** and provide proof thereof.

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

Adults, regardless of age, should receive a single dose of tetanus diphtheria acellular pertussis vaccine (Tdap) for pertussis protection if not previously received in adulthood. **The adult dose is in addition to the routine adolescent booster dose.**

INFLUENZA

Each student is **required** to obtain an annual influenza immunization.

Students will be required to follow Public Health guidelines put forward for health care professionals. The National Advisory Committee on Immunization (NACI) indicates, "Influenza vaccination provides benefits to HCWs and to the patients for whom they care. NACI considers the provision of influenza vaccination to be an essential component of the standard of care for all HCWs for the protection of their patients. This standard applies to any person, paid or unpaid, who provides services, works, volunteers or trains in a health care setting."

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

In the event of an outbreak or for reporting purposes your record of influenza vaccination may be released as necessary.