Northern Ontario School of Medicine
École de médecine du Nord de l'Ontario

NOSM Learner Immunization Form

SECTION A: LEARNER AUTHORIZATION

Learner Name (Please print) ________________________________Date of Birth (yyyy/mm/dd)______________

I authorize the Northern Ontario School of Medicine (NOSM) to use information collected on this form and disclose my personal health information to NOSM teaching and administrative staff, officials of hospitals, health centres, and other organizations related to my NOSM education, including but not limited to, clinical education experiences, community experiences, and electives as required.

I understand that the purpose for collecting, using, and disclosing this personal health information is to ensure compliance with health review and screening standards as required by section 4(2) of the Hospital Management Regulation made under the Public Hospitals Act (Ontario), other related legislation and regulations, and the Ontario Hospital Association/Ontario Medical Association Joint Communicable Disease Surveillance Protocol.

Learner Signature ____________________________ Date (yyyy/mm/dd)________________________________

1. Learners who do not submit the appropriate immunizations records will be **refused, restricted or suspended** from clinical training until proper documentation is provided.
2. Learners are advised to retain a copy of this document for their personal records should a third party request this information.
3. The information collected on this form shall be used to ensure that health review and screening standards set out in the Public Hospitals Act and regulations and other related legislation and organizational policies are met so that learners may participate in clinical activities.
4. Any questions on the collection, use, or disclosure of your health information should be directed to records@nosm.ca

SECTION B: HEALTH CARE PROVIDER VERICATION

The physician or nurse signing below indicates that the information listed on this form is an accurate account of the learner's immune status as of the date shown.

Name of health care professional (please print) ____

Email address ________________________________Telephone ____________________________________

Signature ____________________________________Date (yyyy/mm/dd) ____________________________

1. All antibody titres requested herein **must** be completed as noted.
2. It is not necessary to include copies of laboratory reports unless requested.
3. If more than one clinic/health centre is involved, *please initial the section you completed* and fill out Section D on Page 5.

SECTION C — LEARNER'S HEALTH INFORMATION

A. TUBERCULOSIS

1. Pregnancy is NOT a contraindication for the performance of a Tuberculin skin test (TST).
2. Medical learners—whose TST status is unknown and those previously identified as tuberculin negative—require a baseline **two-step TST** with PPD5/TU **unless** they have:
   a. documented results of a prior two-step TST, **OR**
   b. documentation of a negative TST within the last 12 months, in which case a **single-step** TST may be given.
3. A baseline two-step TST is required once. All further TST's can be a single-step.
4. Interferon-y test results in place of a TST are acceptable, if available.

Past TST History

Prior history of BCG vaccination ☐ No ☐ Yes Date (yyyy/mm/dd) ____________________

Prior history of Positive TST ☐ No ☐ Yes Date (yyyy/mm/dd) ____________________

Prior history of Chest X-ray ☐ No ☐ Yes Date (yyyy/mm/dd) ____________________

Prior History of TB infection ☐ No ☐ Yes Date (yyyy/mm/dd) ____________________

Treatment given ☐ No ☐ Yes Date started (yyyy/mm/dd) ______________
Date finished (yyyy/mm/dd)______________

If past history of two-step TST, indicate dates below.
Date of test #1 (yyyy/mm/dd) ____________________ Results (mm of duration) _______________
Date of test #2 (yyyy/mm/dd) ____________________ Results (mm of duration) _______________

Most recent single-step TST (yyyy/mm/dd) ___________________Results (mm of induration) _____________

1. If your most recent TST was over **12 months ago**, a one-step TST is required.
2. If you have a documented **positive** TST, the learner should not receive another TST.
3. Based on the information provided above, **complete the information below** for the type of TST that is required (i.e. two-step or single-step TST).

Two-step TST (if required)
Date of test #1 (yyyy/mm/dd) ____________________ Results (mm of duration) _______________
Date of test #2 (yyyy/mm/dd) ____________________ Results (mm of duration) _______________

One-step TST (if required)
Date of last one-step (yyyy/mm/dd) ______________ Results (mm of duration) ________________

Additional Information
Date of most recent chest X-ray (yyyy/mm/dd) ____________________
Results____

Do you have any symptoms of pulmonary TB at this time? ☐ Yes ☐ No

Date (yyyy/mm/dd) ___________________________________Results: ________________________________

B. Tetanus Diphtheria (Td)

Dates of primary series (yyyy/mm/dd)____________________ ______________________ _________

Date of last Td immunization (yyyy/mm/dd) ____

If the last dose was **10 years ago** or over, or, **if you were under 18 years of age**, a Td booster is required.

Date of Td Booster (yyyy/mm/dd) ____

C. Pertussis (Whooping Cough)

A single dose of Acellular Pertussis in the form of a Tdap (Adacel vaccine) is given if not previously received as an adult (18+), in place of a Td booster.

Date of Tdap immunization (yyyy/mm/dd) ____

Dates of primary vaccine series (yyyy/mm/dd) ________________ __________________ _____________

D. Polio

Dates of primary series (yyyy/mm/dd) ___________________ ____________________ ____________

Date of last booster (yyyy/mm/dd) ____

E. Measles/Mumps/Rubella (MMR)

MMR antibodies serology to **each of three viruses** is required if there is no documented proof of receipt of **two** MMR vaccines.

MEASLES Antibody Date (yyyyy/mm/dd) __________________ Results _______________________

MUMPS Antibody Date (yyyy/mm/ddd)___________________ Results________________________

RUBELLA Antibody Date (yyyy/mm/dd)____________________Results ________________________

MMR Vaccines Date first MMR given (yyyy/mm/dd) ________________________________

Date second MMR given (yyyy/mm/dd) ________________________________

F. Varicella (Chicken Pox)

Medical learners must demonstrate evidence of immunity. Only the following are acceptable:

- VZV antibodies, OR
- Documentation of 2 doses of a varicella containing vaccines, OR
- A health care provider diagnosis of varicella that is lab-confirmed.

Results of VZV antibody _________________Date(yyyy/mm/dd)________________________

If **non-immune**, the varicella vaccine is required.

Date of 1st dose of varicella vaccine (yyyy/mm/dd) ____________________________________

Date of 2nd dose of varicella vaccine (yyyy/mm/dd) ____________________________________

Lab-confirmed varicella ____

G. Hepatitis B

A complete series of Hepatitis B vaccine is required as well as an anti-Hbs antibody titre at least one month after completion of a 2, 3 or 4-dose series.

Date of 1st Dose: ________________________
(yyyy/mm/dd)

Date of 2nd Dose: ________________________
(yyyy/mm/dd)

Date of 3rd Dose: ________________________
(yyyy/mm/dd)

Additional doses: ________________________
(yyyy/mm/dd)

____
(yyyy/mm/dd)

Serology for Hepatitis B antibody titres (anti-HBs) is required at least one month after the Hepatitis B immunization series is completed.

Results of anti-HBs titres

Immune ☐ Non-immune ☐

Date of titres:__________________
(yyyy/mm/dd)

If the anti-HBs titre is below 10 IU/L, a second series is recommended.

1st Dose (yyyy/mm/dd)	
2nd Dose (yyyy/mm/dd)	
3rd Dose (yyyy/mm/dd)	

At least one month after the above series is completed, have a repeat anti-Hbs titre done.

Date of test (yyyy/mm/dd) ___________________________

Results________ ☐ Immune ☐Non-Immune

If the repeat anti-HBs results are below 10 IU/L, no further Hep B immunizations are recommended and the learner will be considered a non-vaccine responder and counseled to be vigilant in preventing and following-up after needle stick injuries or any other potential exposure to Hepatitis.

It is recommended that learners consider receiving Hepatitis A immunization. Although nosocomial infections are rare, there is a potential for HAV transmission in the health care setting. It is also recommended that learners who rotate through the diagnostic microbiology laboratory should receive N.meningitidis vaccination (quadrivalent).

H. Influenza

Annual influenza (flu) vaccination is **strongly recommended** and is best received by December 1st of each year. Medical learners who choose not to have an annual influenza vaccination should note that hospital policies may preclude them from clinical placements or require antiviral prophylaxis and immunization in the event of an influenza outbreak. The National Advisory Committee on Immunization (NACI) considers the provision of influenza vaccination to be an essential component of the standard of care for all health care workers (HCW) for the protection of their patients. This includes any person, paid or unpaid, who provides services, works, volunteers or trains in a health care setting.

Learners who have direct patient contact should consider it their responsibility to provide the highest standard of care, which includes an annual influenza vaccination. In the absence of contraindications, refusal of learners to be immunized against influenza implies failure in their duty to care for patients.

Date of most recent flu vaccine (yyyy/mm/dd) ____

I. MASK FIT

Have you ever been fit tested for an N-95 mask? Yes ☐ No ☐

If you answered **yes**, please complete the following and **attach your mask fit testing certificate**.

Date (yyyy/mm/dd) ______________ N-95 Mask Type and Size ________________________________

N-95 Mask Fit Testing is required every **two years**. If you have **never** been fit tested for an N-95 mask or the date of your last fit test was over two years ago, an appointment will be made for you to have one done.

SECTION D — HEALTH CARE CENTRE VERIFICATION

If more than one clinic/health care centre is involved in providing results, please initial the section you completed, sign below and complete contact information.

The physician or nurse signing below indicates that the information they have entered on this form is an accurate account of the learner's immune status as of the date shown.

Name of health care professional ____

Signature____ Date (yyyy/mm/dd) ______________________

Clinic Name and Address ____

Clinic Telephone Number ____________________________________ Clinic Fax Number ______________________

Name of health care professional ____

Signature____ Date (yyyy/mm/dd)______________________

Clinic Name and Address ____

Clinic Telephone Number ____________________________________ Clinic Fax Number ______________________

Please return this completed ORIGINAL form to:

Northern Ontario School of Medicine
Student Records & Electives Officer
HSERC 100C
935 Ramsey Lake Road
Sudbury, ON P3E 2C6
Fax: 807-766-7485 E-mail: Records@nosm.ca

The Northern Ontario School of Medicine, as the Faculty of Medicine for Laurentian University and Lakehead University, collects personal information for the purpose of administering learner programs including admissions, registration, academic advising, academic progression, School related student activities and services, information and library systems, financial accounts, assistance, awards and scholarships, graduation, university advancement, alumni relations, research and statistical reporting to government agencies. Information may be shared with Lakehead University, Laurentian University, and Northern Community Hospitals as required to administer learner programs. We respect your privacy and at all times your information will be protected in accordance with the Freedom of information and Protection of Privacy Act. Direct any questions regarding this collection to the NOSM Student Records & Electives Officer, Shanna Leclair, East Campus, records@nosm.ca.

FYI's

- Please keep a copy of the completed NOSM Learner Immunization Form for your records as you will be asked to provide a copy while out on placement. Also, keep any updates you receive throughout your academic career.
- Tuberculosis – if you have never had a 2-step TB test done (only a 1-step or none at all), a 2-step is REQUIRED.
- For years 2 to 4 of the program, you will be required to receive a 1-step Tuberculosis tests upon expiration of your previous test.
- T-dap Boosters – A booster will be required if your last immunization occurred under the age of 18 years of age, even if your current immunization is up to date.

Revised April 2015 to reflect current COFM Immunization Policy