Learner Name:_____

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

NOSM Learner Immunization Form

SECTION A: LEARNER AUTHORIZATION

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

Date of Birth:(yyyy/mm/dd)_____ Home Medical School(Visiting Elective): _____

Admission year to medical school: _____ Expected year of graduation: _____

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 centers, 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.

I acknowledge that to the best of my knowledge the personal health information provided in this form is completely accurate.

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.

Learner Name:_____

SECTION B: HEALTH CARE PROFESSIONAL (HCP) VERIFICATION

Every HCP who completes any part of this form must complete this section. By signing below the HCP indicates that the information listed on this form is an accurate account of the learner's immune status as of the date shown.

Postgraduate residents may complete and sign this immunization form confirming the veracity of their own information.

Name of HCP (please print) _____ Profession: _____

Address: _____

Email address _____ Telephone _____ Fax: _____

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 HCP is involved, complete additional Section B found on Page 6.
4. Section D contains the requirements for NOSM and Visiting Elective Learners

SECTION C. EXCEPTIONS and CONTRAINDICATIONS 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:

Details:_____

_____

_____

OR attach relevant information from a physician(i.e. unable to receive vaccines due to current use of biological agent)

☐ Relevant information from a physician attached

Affected learners must complete the ***Exceptions and Contraindications to Immunization and Testing Requirements, Self-Declaration Form (Appendix A) on page 7.***

Learner Name:_____

SECTION D — LEARNER'S HEALTH INFORMATION

A. TUBERCULOSIS (TB)

1. **Past TB History:** Do any of the following apply?

   1) Documented positive tuberculin skin test (TST) ☐ No ☐ Yes
   Date of Positive TST test (yyyy/mm/dd) _____ Results (mm of duration) _____

   2) Previous diagnosis and/or treatment for TB disease or TB infection ☐ No ☐ Yes

   If "**Yes**" on either of the two questions above: the learner must complete the ***"Tuberculosis Awareness, and Signs and Symptoms Self-Declaration Form" (Appendix B***) on page 8.
   NOTE: Learners with Positive TST results do **not** need to have repeat TSTs.

2. **Chest X-ray**: If a learner has a positive TST or TB history, the learner must submit a chest X-ray report or letter from a physician/TB specialist.
   Chest X-ray post Positive TST (yyyy/mm/dd)_____ Result_____

   Most recent chest X-ray(yyyy/mm/dd)_____ Results_____
   If any abnormalities of the lung or pleura are noted on the chest x-ray report, documentation from a physician is required.

3. **TST:** If "**No**" applies to question 1, **documentation of a baseline two-step TST is required** (two separate tests in different sites, ideally 7-28 days apart but may be given up to 12 months apart).
   A two-step given at any time in the past is acceptable and a baseline two–step TST does **not** need to be repeated. **All further TSTs after the baseline 2 step TST are single-step TSTs**.

   Previous Bacillus Calmette–Guerin (BCG) vaccination is not a contraindication to having a TST.
   An IGRA test would be acceptable in lieu of a TST for international learners with no access to a TST (current within six months of medical school entry).
   Baseline Two-step TST
   Step 1 (yyyy/mm/dd) _____ Results (mm of duration) _____

   Step 2 (yyyy/mm/dd) _____ Results (mm of duration) _____
   NOTE: If the two-step TST was done more than six months prior to medical school entry, a single step TST is required.
   Single-step TST:(yyyy/mm/dd) _____Results (mm of duration) _____

   Most recent single step TST: (if not documented above)

   Date (yyyy/mm/dd) _____ Results (mm of duration) _____

B. TETANUS DIPHTHERIA (Td) and POLIO

Primary Series Td vaccines (yyyy/mm/dd)#1_____#2 _____ #3 _____

Date of last Td Vaccine (yyyy/mm/dd) _____
Note: If the last Td booster was **over 10 years ago**, a Td booster is required.

Primary series of Polio (yyyy/mm/dd) #1 _____ #2_____ #3 _____

Date of last Polio Vaccine: (yyyy/mm/dd) _____

Learner Name:_____

C. PERTUSSIS (Whooping Cough)

A one-time acellular pertussis containing immunization (Tdap or Tdap-Polio) given at age 18 years or older **is required**.

Date of Tdap or Tdap-Polio immunization (yyyy/mm/dd) _____

D. MEASLES/MUMPS/RUBELLA (MMR)

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 is required **AND**

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 is required **AND**

One dose of live rubella-containing vaccine given on or after 12 months of age is required.

Measles, Mumps, Rubella Vaccine #1 (yyyy/mm/dd) _____

#2 (yyyy/mm/dd) _____

Additional MMR vaccines given yyyy/mm/dd _____

OR Positive serology for measles, mumps and rubella antibodies (IgG) is required

MEASLES Antibody Date: (yyyy/mm/dd)_____ Immune ☐ Non-Immune ☐

MUMPS Antibody Date: (yyyy/mm/dd)_____ Immune ☐ Non-Immune ☐

RUBELLA Antibody Date: (yyyy/mm/dd) _____ Immune ☐ Non-Immune ☐

E. VARICELLA (Chicken Pox)

One of the following is required as evidence of immunity:

- Positive serology for Varicella antibodies, OR
- Documentation of 2 doses of a varicella containing vaccines, OR
- Lab evidence of varicella infection

VZV Antibody Date: (yyyy/mm/dd) _____ Immune ☐ Non-Immune ☐

If non-immune, Varicella vaccine is required.

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

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

OR Lab-confirmed varicella (yyyy/mm/dd) _____

Learner Name:_____

F. HEPATITIS B

A complete series of Hepatitis B vaccine and an anti-HBs antibody titre done at least one month after completion of series **is required** to ensure immunity to Hepatitis B.

Hep B vaccine #1(yyyy/mm/dd) _____

Hep B vaccine #2 (yyyy/mm/dd) _____

Hep B vaccine #3 (yyyy/mm/dd _____ (If 3 dose series)

Anti-HBs titre Date: (yyyy/mm/dd) _____Immune ☐ Non-immune ☐

If the anti-HBs titre is **below 10IU/L,** a second Hep B series **is recommended** with a **repeat anti-HBs titre** after.

Repeat Hepatitis B vaccine series or Hepatitis B booster(s)

Hep B vaccine #4 (yyyy/mm/dd) _____ (If required)

Hep B vaccine #5 (yyyy/mm/dd) _____ (If required)

Hep B vaccine #6 (yyyy/mm/dd) _____ (If 3 dose series)

Repeat anti-HBs Date (yyyy/mm/dd) _____Immune ☐Non-immune ☐

If the repeat anti-HBs result is below 10 IU/L, no further Hep B immunizations are recommended. This learner is considered a Hepatitis B Vaccine Non-Responder.

HBsAg blood test **is required**. Date: (yyyy/mm/dd) _____ Positive ☐Negative ☐

Learners who are **HBsAg Positive** (i.e. presence of chronic Hepatitis B infection) must familiarize themselves with the policies of the medical schools where they wish to apply.

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).

Learner Name:_____

G. INFLUENZA

Annual influenza (flu) vaccination is **required** for NOSM and for Visiting Electives Learners occurring during November to June inclusive. If the vaccine is not currently available, document the immunization once the vaccine becomes available (typically mid-October) and resubmit this updated form to applicable schools.

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

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.

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.

H. N-95 MASK FIT TEST

Have you ever been fit tested for an N-95 mask? Yes ☐ No ☐
If answered **yes**, please complete the following and **attach your mask fit testing certificate**.

Date (yyyy/mm/dd) _____ N-95 Model _____ Size _____
N-95 Mask Fit Testing **is required every two years**.

NOTE: **NOSM Medical School Learners.** 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 would be made for you to have one done.

Visiting Electives Learners– If it has been over 2 years since your last N-95 mask fit test, you must book a retest prior to your placement.

SECTION B — HEALTH CARE PROFESSIONAL (HCP) VERIFICATION

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

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 _____

Learner Name:_____

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

This form is to be completed by the learner

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 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.

_____

Student Name

_____

Signature

_____

Date

NOTE: If an appendix is not needed it does not need to be submitted with an application

Learner Name:_____

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

This form is to be completed by the learner

This section applies only to learners 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

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 (attach correspondence from a clinician explaining the symptoms): _____

_____

_____

_____
Learner Name

_____
Signature

_____
Date (yyyy/mm/dd)

NOTE: If an appendix is not needed it does not need to be submitted with an application