Health Screening Update Form

Student Name: _____

Program: _____

Submit this form to the Health Screening Office. KEEP A COPY FOR YOUR FILES. Instructions for submission are on the Health Screening website https://fhs.mcmaster.ca/healthscreening/formsandsubmission.html

Health Screening Office contact: hrsadmin@mcmaster.ca, (905) 525-9140 ext 22249, confidential fax 905-528-4348

HCP to document outstanding requirements for tuberculin skin testing (TST) and NEW vaccinations ONLY on this page (or attach copies of official records). **Please do not repeat what is already documented on the Year One Health Screening Record or previous update forms.**

Tuberculosis (TB): Complete TST before giving a live vaccine (MMR, Varicella)

DATE TST given	DATE TST read	mm induration	Interpretation	HCP Initials

Positive TST documented: Chest x-ray report dated subsequent to positive TST must be attached. A medical assessment should be performed under the direction of a physician. In the absence of active TB disease, a referral should be considered for assessment and treatment of latent TB infection. It is important for the student to be aware of the symptoms of active TB disease and to seek prompt medical attention if any symptoms develop (cough lasting three or more weeks; coughing up blood; shortness of breath; chest pain; fever; chills; night sweats; unexplained or involuntary weight loss).

* **HCP TO VERIFY:** Student does not currently have any symptoms of active TB disease. HCP Initials ____

Vaccinations:

	NEW Vaccine DATE	Vaccine Name	HCP Initials	AGE (years)
Tdap				
Tetanus-Diphtheria				
Polio				
MMR				
Varicella				
Hepatitis B				

MMR and Varicella vaccines must be given either at the same time or spaced at least 28 days apart.

HAHB vaccine (Twinrix) or HB vaccine (Recombivax HB, Engerix-B) may be given to continue a Hepatitis B vaccination series which was started with HB vaccine, using the age appropriate dose and schedule.

Health Care Professional (HCP) Information: Item(s) documented above must be initialed.

Name: _____ Profession: _____ Initials: _____

Signature: _____ Date: _____

Office stamp or address/telephone: