

## Undergraduate Medicine Visiting Electives Immunization Form

**ALL IMMUNIZATION DOCUMENTS MUST BE SUBMITTED DIRECTLY TO THE MCMASTER HEALTH SCREENING OFFICE** (NOT the AFMC Portal or Visiting Electives Office).

More information and instructions for submission can be found on our website: [McMaster Health Screen Electives](#)

**Completing this Form:** Students can print this form and have it completed by an appropriate health care professional (HCP), i.e., a nurse, physician, physician assistant, or pharmacist; the item(s) documented must be within the HCP's scope of practice. Students must not complete any part of this form with the exception of Section A and (if indicated) Appendices A, B and D; the remainder of the form is to be completed by the HCP. Close family members and postgraduate residents must not complete the form.

Completed McMaster University Immunization Form **must be submitted at the same time as your application**. Submit on time even if all the requirements have not been completed. Only the completed McMaster University Immunization Form is accepted as proof of immunization. Other immunization records may be attached as supporting documentation only.

Keep the original of all documents in case they are required by your clinical placement. **Documents submitted to the Health Screening Office are not retained.**

Students with a confirmed elective must have immunization documents reviewed AND cleared by the McMaster Health Screening Office. Outstanding requirements must be completed no later than **8 weeks** prior to the start of the elective or the elective may be cancelled. International students who cannot access specific requirements in their home country will be given extra time to complete the requirements before their elective start date after they arrive in Canada.

**Additional Requirements:** Individual placement sites may have additional requirements not included in this form (i.e. more recent TB skin test or chest x-ray). **Students are responsible** to apprise themselves of these requirements and provide documentation directly to the placement site.

### Section A. Student Declaration

All students must abide by the following declaration:

1. I understand that the personal health information provided in this form shall be kept confidential and will be used by McMaster University only for the purposes of a visiting elective. The information provided will be used by the minimal number of individuals required, as part of my visiting elective application process to ensure that I meet its health standards or the ones of the relevant health authorities or clinical sites.
2. I acknowledge that to the best of my knowledge the personal health information provided in this form is completely accurate.
3. I have not completed any part of this form myself, with the exceptions of this section and (if applicable) Appendices A, B and D. An appropriate health care professional must complete all other sections and appendices.

My signature below indicates that I have read, understood, and agree to the above three items.

Last name: \_\_\_\_\_ Given name(s): \_\_\_\_\_

Date of birth (yyyy-mm-dd): \_\_\_\_\_ Home medical school: \_\_\_\_\_

Year of admission to medical school: \_\_\_\_\_ Expected year of graduation: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section B. Health Care Professional (HCP) Information**

Every HCP who completes any part of this form must complete this section. HCP initials verify the HCP has either provided the service or the HCP has reviewed the student's adequately documented records. If more than three HCPs are involved with completing this form, print a second copy of page 2.

**HCP #1**

Name: \_\_\_\_\_ Profession: \_\_\_\_\_ Initials: \_\_\_\_\_  
 Address: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HCP #2**

Name: \_\_\_\_\_ Profession: \_\_\_\_\_ Initials: \_\_\_\_\_  
 Address: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HCP #3**

Name: \_\_\_\_\_ Profession: \_\_\_\_\_ Initials: \_\_\_\_\_  
 Address: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section C. Exceptions and Contraindications to Immunization 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 OR attach relevant information from a physician (for example: "unable to receive live vaccines due to current use of a biological agent"). Affected students must complete the ***Exceptions and Contraindications to Immunization and Testing Requirements, Self-Declaration Form (Appendix A)***

Details:

- Relevant information from a physician attached

**Section D. Pertussis**

Document a one-time acellular pertussis containing immunization (**Tdap**) given at age 18 years or older:

Date	Type of vaccine used*	Age received	HCP Initials

\* The precise type of vaccine used must be known; if this information is no longer available, repeat the immunization.

**Section E. Tetanus, Diphtheria, and Polio**

Document the last three tetanus/diphtheria and polio containing immunizations (minimum one month between first two doses of a series; minimum six months between last two doses; last tetanus/diphtheria immunization must be within the past **ten years**):

	Tetanus/diphtheria, Date	Polio, Date	HCP Initials
Vaccine 1:			
Vaccine 2:			
Vaccine 3:			

## Section F. Tuberculosis (TB)

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

- Yes  No Documented positive tuberculin skin test (TST) (test result to be documented in the table below), clear history of blistering TST reaction, and/or a positive interferon gamma release assay (IGRA) test (attach report).
- Yes  No Previous diagnosis and/or treatment for TB disease or TB infection

If “Yes” applies to the student on either of these two questions: the student must complete and attach the **Tuberculosis Awareness, and Signs and Symptoms Self-Declaration Form (Appendix B)**; these students should not have a repeat TST; skip to #4 below.

2. **Two-step TST:** If “No” applies to the student on each of the above two questions, documentation of a two-step TST is required (two separate tests, ideally 7-28 days apart but may be up to 12 months apart). A two-step given at any time in the past is acceptable; a two-step TST does not need to be repeated. An IGRA test will be accepted in lieu of a TST for international students with no access to a TST (current within six months of medical school entry).

**Two-Step TST:**

	Date Given*	Date Read*	Millimeters of Induration	Interpretation according to Canadian TB Standards <sup>1</sup>	HCP Initials
Step 1					
Step 2					

\* If only a single date is available this is acceptable so long as appropriate spacing between TSTs and/or vaccines can be verified

If the two-step TST was done more than six months prior to medical school entry the student needs to have a single TST performed.

**NOTE:** Individual placement sites may require a more recent TST; students should apprise themselves of requirements and submit documentation directly to the placement site.

**Most Recent TST:** (not including TSTs documented above)

	Date Given*	Date Read*	Millimeters of Induration	Interpretation according to Canadian TB Standards <sup>1</sup>	HCP Initials
Repeat TST					

\* If only a single date is available this is acceptable so long as appropriate spacing between TSTs and/or vaccines can be verified

3. **Recent TB Exposures:** Has the student had any of the following since admission to medical school?

- Yes  No A significant<sup>2</sup> exposure to an individual diagnosed with infectious TB disease
- Yes  No Time spent in a clinical setting with high risk of exposure to infectious TB (e.g., international electives)
- Yes  No Lived or worked in an area of the world with high TB incidence

If “Yes” applies to the student on one or more of these questions the student must complete the **Tuberculosis Awareness, and Signs and Symptoms Self-Declaration Form (Appendix B)**.

	Date Given*	Date Read*	Millimeters of Induration	Interpretation according to Canadian TB Standards <sup>1</sup>	HCP Initials
Repeat TST					

\* If only a single date is available this is acceptable so long as appropriate spacing between TSTs and/or vaccines can be verified

Students found to have a positive TST must also complete and attach the **Tuberculosis Awareness, and Signs and Symptoms Self-Declaration Form (Appendix B)**.

4. **Chest X-ray:** If a student has a positive TST documented or any other positive TB history, the student must submit a chest X-ray report (or letter from a TB physician specialist describing the report). The chest X-ray must be obtained subsequent to the positive TST or positive TB history. A repeat or recent chest X-ray is not required. (Individual placement sites may require a more recent chest-xray; students should apprise themselves of requirements and submit documentation directly to the placement site.)

X-ray required?	Date Obtained	Result	Report Attached	HCP Initials
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes <input type="checkbox"/> No	

If any abnormalities of the lung or pleura are noted on the chest X-ray report, documentation from a physician is required explaining the findings. Physicians may use the form **Explanation of Radiographic Findings (Appendix C)**, or else attach a letter.

<sup>1</sup> Whether a particular TST measurement is considered positive or negative may depend on the client's exposures and risk factors.

<sup>2</sup> Whether an exposure was significant and requires follow-up testing should be determined by the occupational health unit in the facility, or public health unit in the local jurisdiction of the exposure.

## Section G. Measles, Mumps, Rubella, and Varicella

### General Requirements:

ONE of the following items is required as evidence of immunity to **measles**:

1. 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; OR
2. Positive serology for measles antibodies (IgG); OR
3. Laboratory evidence of measles infection.

ONE of the following items is required as evidence of immunity to **mumps**:

1. 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; OR
2. Positive serology for mumps antibodies (IgG); OR
3. Laboratory evidence of mumps infection.

ONE of the following items is required as evidence of immunity to **rubella**:

1. ONE dose of live rubella-containing vaccine, given on or after 12 months of age; OR
2. Positive serology for rubella antibodies (IgG); OR
3. Laboratory evidence of rubella infection.

ONE of the following items is required as evidence of immunity to **varicella**:

1. TWO doses of live varicella-containing vaccine, given six or more weeks apart, with the first dose given on or after 12 months of age; OR
2. Positive serology for varicella antibodies (IgG); OR
3. Laboratory evidence of varicella infection.

### Immunizations:

	Vaccine 1, Date	Vaccine 2, Date	HCP Initials
Measles Vaccine			
Mumps Vaccine			
Rubella Vaccine			
Varicella Vaccine*			

\* For varicella immunizations: while a minimum spacing of six weeks apart is the current standard, a minimum spacing of four weeks apart will be accepted.

**Serology:** For students with no record of measles, mumps or rubella immunizations, a preferred approach is to immunize without checking pre-immunization serology (regardless of age), although testing serology (IgG) is an acceptable alternative to immunization.

For students with no record of varicella immunizations, varicella serology should be tested first.

Post-immunization serology testing for measles, mumps, rubella, or varicella should NOT be done once immunization requirements have been met.

	Test Date	Laboratory Result	Interpretation (Immune or non-immune)	HCP Initials
Measles IgG				
Mumps IgG				
Rubella IgG				
Varicella IgG				

**Laboratory Evidence of Infection:** If a student has laboratory evidence of infection (e.g., isolation of virus; detection of deoxyribonucleic acid or ribonucleic acid; seroconversion) to measles, mumps, rubella, or varicella, this will meet the requirements of immunity for the item.

Name of Test	Test Date	Laboratory Result	HCP Initials

### Section H. Hepatitis B (HBV)

**Immunizations:** Document the hepatitis B containing immunizations administered to date:

	Date	Type of vaccine used *	HCP Initials
Vaccine 1:			
Vaccine 2:			
Vaccine 3 (If required):			
Vaccine 4 (If required):			
Vaccine 5 (If required):			
Vaccine 6 (If required):			

\* If information on the name of the vaccine given is no longer available, simply document the date of the immunization.

**Serology:** If the student is immune, only the most recent positive anti-HBs is required. If the student is a vaccine non-responder who cannot achieve immunity despite two complete hepatitis B series, only the most recent negative post-immunization anti-HBs is required; such students must also complete the form **Hepatitis B Vaccine Non-Responders, Self-Declaration Form (Appendix D)**. All students must have a test for HBsAg conducted on or after the time of the assessment for hepatitis B immunity. (If HBsAg negative after completion of primary vaccination series, repeat testing for HBsAg with repeat anti-HBs if booster doses vaccine required may be omitted.)

	Date	Laboratory result	Interpretation (Immune or non-immune)	HCP Initials
anti-HBs				
HBsAg				

**Students who are HBsAg positive (i.e., presence of chronic hepatitis B infection) must self-report their status to the McMaster University Assistant Dean of Undergraduate Medicine.**

### Section I. Influenza

	Date	HCP Initials
Current seasonal influenza vaccine		

An up-to-date seasonal influenza immunization is required for electives occurring during November to June inclusive.

If vaccine is not currently available, student not required to submit updated documentation to the Health Screening Office; provide proof of current season's immunization directly to the elective placement site.

### Section J. Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV):

- Serologic testing for HCV and HIV is not mandatory; however medical students are likely to participate in exposure-prone procedures and are therefore strongly urged to know their status.
- Students are NOT required to submit results of serologic testing for HCV and/or HIV to the McMaster Health Screening Office.
- **Students who are infected with HCV and/or HIV must self-report their status to the McMaster University Assistant Dean of Undergraduate Medical Education.**

**Appendix A: Exceptions and Contraindications to Immunizations and Testing,  
Self-Declaration Form**

**This box is to be completed by the student:**

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 skin 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

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

**This box is to be completed by the student:**

This section applies only to students 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 (defined in **Section F**)

**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 (also attach correspondence from a clinician explaining the

symptoms): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Appendix C: Explanation of Radiographic Findings**

This form must be completed by a physician who has assessed a student with abnormalities of the lung or pleura noted on a chest X-ray, with chest X-ray report attached (alternatively it is acceptable to attach a letter or form from a tuberculosis clinic or other specialized clinic covering the following items).

Chest X-ray report attached

Reason chest X-ray was obtained: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Explanation for abnormal findings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Given the abnormal findings, does the student pose a risk to others by participating in clinical duties?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Date



**Appendix D: Hepatitis B Vaccine Non-Responders Self-Declaration Form**

**This box is to be completed by the student:**

This section applies only to students who have received two complete, documented hepatitis B immunization series, and post-immunization serology has not demonstrated immunity (i.e., anti-HBs remains less than 10 IU/L)

For a student in this category, it is important to ensure (1) that each immunization series was documented, all doses were provided, and that minimal spacing between doses were respected; and (2) that post-immunization serology was conducted between 28 days and six months after the final dose of the series to be considered reliable. For students in this category generally no further pre-exposure hepatitis B immunizations or testing are required.

My signature below indicates the following:

- I acknowledge that there is no laboratory evidence that I am immune to hepatitis B.
- I acknowledge that in the event of a possible exposure to hepatitis B (e.g., a percutaneous injury or mucosal splash) I may need passive immunization with hepatitis B immune globulin.

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date