Year One Health Screening Record 2018

Midwifery Education Program
MSc Child Life and Pediatric Psychosocial Care
MSc Occupational Health Program
MSc Physiotherapy Program
MSc Speech-Language Pathology Program
Nursing Undergraduate and Graduate Programs
Physician Assistant Education Program
Undergraduate Medical Education Program

Students entering undergraduate and graduate health professional programs at McMaster University must submit this form AND be cleared by the Health Screening Office before they may participate in clinical activities (including clinical skills sessions with fellow students or standardized patients). Personal health information is held in confidence by the Health Screening Office and only disclosed with the consent of the student. Faculty of Health Sciences health screening requirements meet current OHA Communicable Diseases Surveillance Protocols for Ontario Hospitals, in accordance with Regulation 965, Section 4 of the Public Hospitals Act RSO 1990.

- All sections (except where a student's signature is required) must be completed by a qualified health care professional (physician, nurse, physician assistant, pharmacist). Make sure your name is on every page.
- Submit this form by the deadline date for your program to the Health Screening Office (NOT your program office). Submit **on time** with a note of explanation if any requirements are outstanding**. Check over your form before submitting**.
- Keep the original of all documents in case they are required by your clinical placement**. Documents submitted to the Health Screening Office are not returned.**

More information, deadline dates and instructions for submission can be found on the Health Screening website:

https://fhs.mcmaster.ca/healthscreening/firstyearstudents.html

Health Screening Office contact: email hrsadmin@mcmaster.ca, telephone 905-525-9140 ext 22249, office MDCL 3514

1. Student Information – PRINT CLEARLY

Name (last): _____ Name (first): _____

Program: _____ Date of birth: _____

Email for communication with the Health Screening Office: _____

☐ I verify that to the best of my knowledge the health information provided on this form is completely accurate

☐ I verify that I have not completed any part of this form myself, except where my signature may be required (#1, #4, #10, #12C)

Signature: _____ Date: _____

2. Health Care Professional (HCP) Information – HCP initials on this form verify they have either provided the service or they have reviewed the student's adequately documented records. The item(s) documented must be within the HCP's scope of practice.

HCP #1

Name: _____ Profession: _____ Initials: _____

Address: _____

Telephone: _____ Fax: _____

Signature: _____ Date: _____

HCP #2

Name: _____ Profession: _____ Initials: _____

Address: _____

Telephone: _____ Fax: _____

Signature: _____ Date: _____

HCP #3

Name: _____ Profession _____ Intitials: _____

Address: _____

Telephone: _____ Fax: _____

Signature: _____ Date: _____

3. Tuberculosis (TB): HCP to document required tests below

☐ **A. Positive TB history:** Document positive tuberculin skin test (TST) below. Attach records of other positive TB history (blistering TST reaction, or positive IGRA test, or previous diagnosis and/or treatment for active TB disease or latent TB infection). Student should not have a repeat TST. Skip to #3C (Chest x-ray)

	Date TST given	Date TST read	mm induration	HCP Initials
Positive TST				

☐ **B. ◄ OR ► Negative TB history or TB status unknown or not documented:** Document a baseline two-step TST given at any time in the past is required (two separate tests spaced between 7 days and 12 months apart and given either before or at least four weeks after receiving a live vaccine). A two-step test does not need to be repeated. Note previous BCG vaccination is not a contraindication to having a TST.

Two-step TST	Date TST given	Date TST read	mm induration	Interpretation	HCP Initials
Step One					
Step Two					

An additional single TST is required if negative two-step test completed before March 1st in current calendar year

	Date TST given	Date TST read	mm induration	Interpretation	HCP Initials
+/- Single TST					

TB screening after program start:

Students with negative baseline screening who are exposed to active (infectious) TB disease during their program are required to have a single TST eight or more weeks post-exposure, and to report the result to the Health Screening Office. Students who convert to a positive TST during their program must be cleared by the Health Screening Office before they may return to clinical activities. More information can be found on the Health Screening website.

< < If positive TST documented above, go to #3C. If negative TSTs documented above, skip to next page > >

☐ **C. Chest x-ray:** Required only if positive TST or other positive TB history documented in #3A or #3B

Chest x-ray must be dated subsequent to the positive TST or other positive TB history. If the initial x-ray is negative, a more recent x-ray is not required unless medically indicated. If the x-ray is abnormal, a letter from a physician explaining the findings is required. A copy of the x-ray report is required.

☐ Chest x-ray report attached

4. TB Self-Declaration: Student to complete only if documented positive TST or other positive TB history and negative chest x-ray

Student to acknowledge the following:

- I understand that sometimes latent (noninfectious) TB infection can progress to active TB disease even for individuals who have normal chest x-rays, and for those who were successfully treated for active TB disease or latent TB infection in the past.
- I currently do no not have any signs or symptoms of possible TB disease (cough lasting three or more weeks; hemoptysis (coughing up blood); shortness of breath; chest pain; fever; chills; night sweats; unexplained or involuntary weight loss)
- I will obtain a prompt medical assessment from a physician if I develop any signs and symptoms of possible TB disease.

Student signature: _____ Date: _____

Immunizations and Serology – HCP to document required immunizations and serology results in chart below

☐ **5. Pertussis:** ONE Tdap vaccine (tetanus/diphtheria/pertussis) age 18 years or older. Required by Ontario Hospital Association even if not due for a booster. If student is currently age 16 or 17 years (Midwifery and Nursing BSc Stream A students ONLY), document adolescent Tdap given age 14-17 years; a booster will be required on or after the 18th birthday.

☐ **6. Tetanus, Diphtheria, Polio:** Last THREE vaccinations (minimum one month between the first two doses; minimum six months between the last two doses; last tetanus/diphtheria immunization must be within the last ten years). If records missing or incomplete, a fully documented series must be completed (may be in process at program start).

☐ **7. Measles, Mumps, Rubella:** TWO vaccinations for measles and mumps at least 28 days apart, and ONE vaccination for rubella, age 12 months or older ◄ **OR** ► Positive IgG antibody serology – NOT both.
(Vaccination recommended instead of serology for all ages. Serology either before or after vaccination NOT recommended.)

☐ **8. Varicella:** TWO vaccinations at least 28 days apart, age 12 months or older ◄ **OR** ► Positive IgG antibody serology.
(Serology recommended first if history of chicken pox or shingles. Serology after vaccination NOT recommended.)

9. Hepatitis B: (may be in process at program start)

☐ **A. Hepatitis B vaccines** – A fully documented vaccination series according to a recommended immunization schedule must be completed (exception: vaccines not required if student has chronic Hepatitis B infection or is immune due to natural infection – attach records). All previous doses of vaccine count towards the total series as long as minimum spacing requirements are met. If records missing or incomplete, student to sign #10 Hepatitis B Self-Declaration.

☐ **B. ◄ PLUS ► Test for Hepatitis B immunity (anti-HBs)** one or more months after a documented vaccination series.
(Positive anti-HBs serology alone is not considered proof of immunity if Hepatitis B vaccines in #9A are missing or incomplete.)

Anti-HBs ≥ 10 IU/L: Immune. Document most recent post-immunization positive test result. Serology should not be repeated.

Anti-HBs < 10 IU/L: Not immune. Document most recent post-immunization negative test result. Student to sign #10.

- Not immune after ONE documented series: If series completed more than six months ago, ONE booster plus repeat anti-HBs required – If not immune after the first booster, TWO additional boosters spaced five months apart plus repeat anti-HBs required. If series completed 1-6 months ago, a second series (given at 0, 1, 6 months) plus repeat anti-HBs required.
- Not immune after TWO documented series: Student is Hepatitis B vaccine non-responder and unlikely to benefit from further immunizations. Repeat serology not required.

Date of vaccine OR Date of serology	Vaccine type OR Serology test results	Tetanus	Diphtheria	Pertussis	Polio	Measles	Mumps	Rubella	Varicella	Hepatitis B	HCP Initials

(Do not include this page if not required.)

10. Hepatitis B Self-Declaration: Student to complete only if required

Proof of immunity to Hepatitis B requires either:
- Positive anti-HBs serology AND a documented vaccination series according to a recommended schedule, OR
- Immunity due to naturally acquired infection (positive anti-HBs AND positive anti-HBc).

Student to sign this box if one of the following apply:
- Anti-HBs serology not immune (< 10 IU/L), OR
- Hepatitis B vaccinations still in process, OR
- Anti-HBs serology positive with incomplete or undocumented vaccinations

Student to acknowledge the following:
- I acknowledge that I do not have documented proof of immunity to Hepatitis B.
- I acknowledge that in the event of possible exposure (e.g. percutaneous injury or mucosal splash), I may need passive immunization with hepatitis B immune globulin.

Student signature: _____ Date: _____

11. Influenza: Annual influenza immunization for clinical placements occurring between November and April required. Student to provide proof of immunization directly to the placement site.

12. Blood borne viruses (BBV) – Hepatitis B Virus, Hepatitis C Virus and Human Immunodeficiency Virus (HIV)

** REQUIRED FOR MIDWIFERY, PHYSICIAN ASSISTANT, AND UNDERGRADUATE MEDICINE STUDENTS ONLY **

Students in the Midwifery, Physician Assistant, and Undergraduate Medicine programs are likely to perform or assist in performing exposure-prone procedures and are therefore obligated to know their status with respect to blood borne viruses.

☐ **A. Hepatitis B surface antigen (HBsAg) serology:** Required for all students, including students immune to Hepatitis B.

Note: HBsAg (surface antigen) is a different test than anti-HBs (surface antibody); HBsAg tests for chronic Hepatitis B infection and anti-HBs tests for Hepatitis B immunity.

Test for HBsAg must be conducted on or after the time of assessment for Hepatitis B immunity (anti-HBs), OR if the Hepatitis B primary vaccination series is still in process test must be dated after March 1st in the current calendar year (wait until at least 28 days after a Hepatitis B vaccine to avoid the possibility of a false positive result).

	Date of most recent test	Test result		HCP Initials
HBsAg (antigen)			☐ Infection ☐ No infection	

☐ **B. Hepatitis C and HIV serology:**

Tests must be dated after March 1st in current calendar year and are valid for four years. Only the dates of tests are required, verified by a nurse or physician after reviewing the results with the student; results or lab reports are not required.

	Date of most recent test
Hepatitis C antibody	
HIV antibody	

Date results of above tests reviewed with the student: _____

HCP name: _____ HCP signature: _____

C. BBV Self-Declaration: This box to be completed by the student:

- I have reviewed the results of the above tests with a physician or nurse.
- I am aware of my status with respect to blood borne viruses Hepatitis B, Hepatitis C and HIV.
- I will self-report any positive serology for Hepatitis B, Hepatitis C and/or HIV to the Assistant Dean of my program.

Student signature: _____ Date: _____