Year One Health Screening Record
Undergraduate/Graduate Health Professional Programs

Feb 2024

SUBMIT COMPLETED FORM TO THE FHS HEALTH SCREENING OFFICE (HSO) BY JULY 15TH

Contact information and instructions for submission: https://fhs.mcmaster.ca/healthscreening/firstyearstudents.html

**** Learners who are not cleared by the HSO cannot participate in any in-person clinical activities****

LEARNER INFORMATION: PRINT CLEARLY

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

Year of program start: _____ Date of birth (Year/Month/Day): _____

Email (required): _____

Program:

- ☐ Child Life & Pediatric Psychosocial Care
- ☐ Midwifery Education
- ☐ Nursing – Graduate and PHCNP
- ☐ Nursing – Undergraduate Accelerated Stream
- ☐ Nursing – Undergraduate Basic Stream
- ☐ Physician Assistant Education
- ☐ Rehabilitation Science – Occupational Therapy
- ☐ Rehabilitation Science – Physiotherapy
- ☐ Rehabilitation Science – Speech Language Pathology
- ☐ Undergraduate Medical Education

CONFIDENTIALITY: The FHS Health Screening Office (HSO) is collecting your personal information to clear you for the clinical component of your studies. The HSO will not share any of your personal information unless requested by you in writing or as permitted under FIPPA. Furthermore, all documentation will be maintained by the HSO as per the McMaster University Policy for Handling of Personal Health Information.

COMMUNICATION: The FHS Health Screening Office will need to communicate with you regarding the status of your health screening and detail outstanding requirements for clearance. If your preferred method of communication is via email please grant us permission and acknowledge that email is not a secure means for sharing confidential information, by signing and dating below.

Learner signature: _____ **Date:** _____

If you do not wish to communicate via email please specify your preferred method: _____

CHECKLIST: START EARLY

- ☐ Complete and sign the Learner Information section on page 1 (above).
- ☐ Gather any previous records for TB skin testing (TST), immunizations, and any lab reports. ** In Ontario, you can contact the local Public Health Unit nearest where you attended elementary/high school for your immunization records. **
- ☐ Take this form and your previous records to a qualified health care professional (HCP) to review your records and fill in the form (do not fill in the form yourself). The HCP needs to complete any requirements which are not documented on your previous records. We recommend completing the TB section and any required serology (blood tests) first.
- ☐ Each HCP who provides documentation on this form must initial each item and complete the HCP information on page 3 in full. HCP initials/signature verify the HCP has either provided the service or reviewed the learner's adequately documented records. The item(s) documented must be within the HCP's scope of practice.
- ☐ Attach supporting documentation or a letter from a physician if unable to complete any requirement(s) due to a medical reason.
- ☐ Attach copies of required lab/chest x-ray reports. DO NOT ATTACH OTHER RECORDS UNLESS REQUESTED.
- ☐ Make sure your name is on EVERY PAGE submitted and keep a copy of all documents for your files.

Learner name (last): _____ **(first):** _____

1. TUBERCULOSIS (TB): ONE OF THE FOLLOWING: **Complete BEFORE any new MMR/Varicella vaccines are given.**

a) Baseline two-step TST from any time in the past (two separate skin tests given between 7 days and 12 months apart and read after 2-3 days requiring 4 visits to the HCP); AND additional single (one-step) TST given after March 1st this year if not already included in the two-step test. **Note:** TST must be given BEFORE or at least 28 days AFTER a live vaccine (MMR/Varicella).

b) **OR** Positive TST or other positive TB history; AND a chest x-ray dated after the positive TST or other positive TB history.

Date TST given (yyyy/mmm/dd)	HCP Initials	Date TST read (yyyy/mmm/dd)	mm induration	Interpretation	HCP Initials

Complete only if positive TST or other positive TB history documented:

☐ Chest x-ray report attached.

Does the learner currently have any symptoms of active TB disease (persistent cough or fever lasting three or more weeks, hemoptysis, night sweats, unexplained or involuntary weight loss)?	HCP Initials
☐ No ☐ Yes – Letter from a physician required.	

2. MEASLES, MUMPS, RUBELLA, VARICELLA: VACCINES **OR** SEROLOGY

TWO measles vaccines, TWO mumps vaccines, ONE rubella vaccine, TWO varicella vaccines, given at age 12 months or older and spaced at least 28 days apart **OR** Positive IgG antibody serology. **Note:** MMR and Varicella vaccines must be given either at the same time or spaced at least 28 days apart. Vaccines ONLY preferred for measles/mumps/rubella without testing IgG antibody serology either before or after vaccination, although positive IgG antibody serology will be accepted. Varicella IgG antibody serology recommended only if no previous vaccines.

	Date Vaccine1 (yyyy/mmm/dd)	HCP initials	Date Vaccine2 (yyyy/mmm/dd)	HCP initials		Lab report for IgG antibody attached
Measles					OR	☐
Mumps					OR	☐
Rubella					OR	☐
Varicella					OR	☐

3. COVID-19: Primary vaccination series according to the Canadian Immunization Guide**.**

Vaccine Date (yyyy/mmm/dd)	Vaccine type (required)	HCP Initials

4. ONE-TIME PERTUSSIS VACCINE (Tdap) AGE 18 YEARS OR OLDER:

Mandatory for learners even if not due for a booster. Document an adolescent Tdap vaccine age 14-17 years for students currently under age 18 years.

Date Vaccine (yyyy/mmm/dd)	Vaccine type (required)	Age (years)	HCP Initials

5. TETANUS, DIPHTHERIA, POLIO: Primary vaccination series; AND tetanus/diphtheria booster in last 10 years.

Document the last 3 vaccines that meet minimum spacing requirements (one or more months between the first two doses, six or more months between the last two doses). Tdap vaccine above counts as one tetanus/diphtheria dose.

	Tetanus/Diphtheria (yyyy/mmm/dd)	HCP Initials	Polio (yyyy/mmm/dd)	HCP Initials
Last				
Previous				
Previous				

Learner name (last): _____ **(first):** _____

6. HEPATITIS B (HB): VACCINES **AND** SEROLOGY

a) Primary vaccination series at age appropriate schedule and dosages (unless a history of naturally acquired infection or chronic infection is documented). If previous records missing or incomplete, a documented 3-dose series must be completed. All documented vaccines count towards the series as long as minimum spacing requirements are met.

b) **AND** anti-HBs / HB surface ANTIBODY serology (test for immunity) dated one or more months after completion of a documented primary vaccination series. Do not repeat previous positive post-series serology.

c) Booster vaccine(s) and repeat anti-HBs serology required if not immune after the primary vaccination series (anti-HBs < 10 IU/L). More information can be found on the Health Screening website.

Date HB Vaccine (yyyy/mmm/dd)	+/- Vaccine type	HCP Initials	Date HB Vaccine (yyyy/mmm/dd)	+/- Vaccine type	HCP Initials
☐ Lab report(s) for most recent positive and/or negative anti-HBs serology attached					

7. BLOOD BORNE VIRUSES (BBV): **Midwifery, Physician Assistant, Undergraduate Medicine ONLY*

a) Report for HBsAg / HB surface ANTIGEN serology (test for chronic Hepatitis B infection) dated one or more months after completion of a documented primary vaccination series; OR if the series is in process, baseline test dated after March 1st this year plus repeat test after the series is completed. **Have this test BEFORE any new Hepatitis B vaccines are given (can be the same day), otherwise you must wait at least 28 days after vaccination to avoid the possibility of a false positive result.

b) HIV and Hepatitis C (HCV) serology dated after March 1st this year. Reports not required but may be submitted in place of the HCP completing the section below.

Note: Learners in the Midwifery, Physician Assistant, and Undergraduate Medicine programs must SELF-REPORT any positive test results to their Assistant/Associate Dean. Testing and/or reporting is NOT required for other programs.

HBsAg (HB surface ANTIGEN) ☐ Lab report attached		Date of test (yyyy/mmm/dd)	Results reviewed with learner	HCP Initials
	HIV		☐	
	HCV		☐	

HEALTH CARE PROFESSIONAL (HCP) INFORMATION: Initial each item documented and complete the information below:

#1 HCP Name: _____ Profession: _____ Initials _____ Signature: _____ Date: _____	Office stamp or Address/Telephone
#2 HCP Name: _____ Profession: _____ Initials _____ Signature: _____ Date: _____	Office stamp or Address/Telephone
#3 HCP Name: _____ Profession: _____ Initials _____ Signature: _____ Date: _____	Office stamp or Address/Telephone