Year One Health Screening Record
Undergraduate/Graduate Health Professional Programs

Child Life & Pediatric Psychosocial Care
Midwifery Education
Nursing Graduate and Undergraduate
Occupational Therapy
Physician Assistant Education
Physiotherapy
Speech Language Pathology
Undergraduate Medical Education

DEADLINE FOR SUBMISSION (submit even if not 100% complete): JULY 15TH PRIOR TO PROGRAM START
SUBMIT THIS FORM TO THE HEALTH SCREENING OFFICE (not your program office)

More information and instructions for submission are on the Health Screening website:
https://fhs.mcmaster.ca/healthscreening/firstyearstudents.html

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

Learners entering Faculty of Health Sciences health professional programs must complete the health screening requirements on this form as part of the non-academic requirements for their program. All health screening documentation must be reviewed and cleared by the Health Screening Office before students may participate in clinical activities (interaction with patients in the clinical setting or as research subjects, and clinical skills sessions with fellow students and/or standardized patients, either virtual or in person).

Personal health information provided is protected and is being collected pursuant to the Freedom of Information and Protection of Privacy Act of Ontario (RSO 1990). This information will be held in strict confidence within the Faculty of Health Sciences Health Screening Office and only disclosed as needed with the consent of the student.

Checklist for students: START EARLY as some requirements may take several weeks to complete.

☐ LOCATE ANY PREVIOUS RECORDS FOR THE FOLLOWING:
  • Tuberculin skin testing (TST) and/or other records regarding tuberculosis (TB)
  • Vaccinations: Tetanus, Diphtheria, Polio, Pertussis, Measles, Mumps, Rubella, Varicella, Hepatitis B
  • Lab tests: Varicella, Hepatitis B
Records may be obtained from a family physician or other primary care provider, Occupational Health Services if you worked or volunteered in a hospital, or Public Health Services if you attended public school in Canada. We also accept the yellow immunization card, and previously completed immunization forms.

☐ Translate records into English if applicable (student may translate).

☐ Complete the student information on page 2. An email address is required for communication with the Health Screening Office.

☐ Have a qualified health care professional (HCP) complete and document requirements listed on page 3 and 4 which are not documented on previous records. Note, you may visit student health services (open year round) once you have been assigned a student number. Make sure each HCP who provides documentation on the form fully completes Section B on page 2.

☐ Attach a letter from a physician if you are unable to complete any of the requirements listed due to a medical condition, or if you have a current or past medical history requiring special consideration (e.g. vaccine allergy, immune deficiency).

☐ Medical students ONLY: Complete Section E. on page 5.

☐ KEEP A COPY OF ALL DOCUMENTS FOR YOUR FILES.

☐ Submit this form with previous records and required reports attached ON TIME. Make sure your name is on every page

☐ DO NOT ALTER THIS FORM AFTER SUBMISSION. A separate update form will be provided for outstanding requirements.

DO NOT SUBMIT THIS PAGE
SECTION A. Student 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 (undergraduate basic and accelerated)
☐ Nursing (graduate and PHCNP)
☐ Occupational Therapy
☐ Physician Assistant Education
☐ Physiotherapy
☐ Speech Language Pathology
☐ Undergraduate Medical Education

SECTION B. Health care professional (HCP) information: Each HCP who provides documentation on this form must complete this section and initial each item documented. Items documented must be within the HCPs scope of practice. **Duplicating data from previous records is not necessary.** Copy this page if needed.

HCP Name: ________________________________________ Profession: ______________________ Initials _________
Signature: ________________________________________ Date: ____________________________

HCP Name: ________________________________________ Profession: ______________________ Initials _________
Signature: ________________________________________ Date: ____________________________

Address/Telephone: ________________________________________________________________________________

HCP Name: ________________________________________ Profession: ______________________ Initials _________
Signature: ________________________________________ Date: ____________________________

Address/Telephone: ________________________________________________________________________________

HCP Name: ________________________________________ Profession: ______________________ Initials _________
Signature: ________________________________________ Date: ____________________________

Address/Telephone: ________________________________________________________________________________

+/- office stamp
Year One Health Screening Record

Student name (last): ___________________________ (first): ___________________________

SECTION C: The following must be FULLY completed for provisional clearance (deadlines determined by the Health Screening Office). N.B. Students who are not cleared or provisionally cleared cannot participate in clinical activities and may be excluded from class by their Program.

1. **Tuberculosis (TB):** ONE of the following:
   a) Baseline two-step tuberculin skin testing (TST) from any time in the past (two separate tests given 7 days to 12 months apart), regardless of history of BCG vaccination; AND additional single TST given after March 1st this year if the last negative TST was given before March 1st. **N.B. TST must be given either before or at least 28 days after a live vaccine (MMR, Varicella).**
   b) **OR** Positive TST (date and mm induration MUST be documented), or other positive TB history (blistering TST reaction, positive IGRA serology, previous diagnosis and/or treatment for TB); AND a chest x-ray dated subsequent to the positive TST or other positive TB history. Note, BCG is an unlikely reason for a positive test if the vaccine was given before age 12 months.

   - □ Chest x-ray report attached

   **Abnormal chest x-ray and/or symptoms of TB disease?** Symptoms include: Cough lasting three or more weeks; hemoptysis; shortness of breath; chest pain; fever; chills; night sweats; unexplained or involuntary weight loss.

   - □ NO: Note that latent (inactive) TB infection can sometimes progress to active (infectious) TB disease, even for individuals with normal chest x-rays and for those who were successfully treated for TB in the past. The risk is increased by immunosuppression (immunodeficiency disorders or immunosuppressive medications).

   - □ YES: Letter from a physician required.

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<thead>
<tr>
<th>Step one</th>
<th>Step two</th>
<th>Recent</th>
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<tbody>
<tr>
<td>DATE TST given (Year/Month/Day)</td>
<td>DATE TST read (Year/Month/Day)</td>
<td>mm induration</td>
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2. **Pertussis:** One Tdap vaccine (tetanus-diphtheria-pertussis) **AGE 18 YEARS OR OLDER.** MANDATORY for health care workers/learners, even if not due for a booster; interval from last tetanus/diphtheria containing vaccine does not matter. Students currently under age 18 years will be granted provisional clearance for this requirement until after their 18th birthday.

<table>
<thead>
<tr>
<th>DATE vaccine (Year/Month/Day)</th>
<th>Vaccine TYPE (required)</th>
<th>AGE (years)</th>
<th>HCP Initials</th>
</tr>
</thead>
</table>

3. **Measles, Mumps, Rubella:** Two measles vaccines, two mumps vaccines, and one rubella vaccine, given at age 12 months or older and spaced at least 28 days apart. IgG antibody serology is NOT recommended either before or after vaccination and will not be accepted.

<table>
<thead>
<tr>
<th>DATE vaccine 1 (Year/Month/Day)</th>
<th>HCP Initials</th>
<th>DATE vaccine 2 (Year/Month/Day)</th>
<th>HCP Initials</th>
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<tbody>
<tr>
<td>Measles</td>
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<td>Mumps</td>
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<td>Rubella</td>
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4. **Varicella:** ONE of the following:
   a) Two varicella vaccines given at age 12 months or older and spaced at least 28 days apart. If one previous vaccine, a second vaccine is mandatory. **N.B. MMR and varicella vaccines must be given either at the same time or spaced at least 28 days apart.**

<table>
<thead>
<tr>
<th>DATE vaccine 1 (Year/Month/Day)</th>
<th>HCP Initials</th>
<th>DATE vaccine 2 (Year/Month/Day)</th>
<th>HCP Initials</th>
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<tbody>
<tr>
<td>Varicella</td>
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   b) **OR** Positive varicella IgG antibody serology. Do not repeat previous serology. Serology recommended if no previous vaccines. Serology tested AFTER vaccination is NOT recommended and will not be accepted.

   □ Report for Varicella IgG antibody serology attached
Year One Health Screening Record

Student name (last): ________________________________  (first): ________________________________

SECTION D: The following may be in process at program start (deadlines determined by the Health Screening Office).

5. **Tetanus, Diphtheria, Polio:** Documented vaccination series (minimum 3 doses). Minimum one month between the first two doses; minimum 6 months between the last two doses. Tdap vaccine on page 3 counts as one tetanus/diphtheria dose.

<table>
<thead>
<tr>
<th>DATE vaccine (Year/Month/Day)</th>
<th>Vaccine TYPE (required)</th>
<th>HCP Initials</th>
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6. **Hepatitis B (HB):** BOTH of the following:
   - **a)** Documented vaccination series at age appropriate dosages and schedule. Exception: Vaccines not required if chronic Hepatitis B infection or immunity due to naturally acquired infection is documented.
   - **b)** **AND** **Serology for immunity (anti-HBs) tested at least 28 days after the last dose in a documented vaccination series. Do not repeat previous positive post-immunization serology. Positive serology alone is not considered proof of immunity if documented vaccines are missing or incomplete and will not be accepted.

   [ ] Report(s) for post-immunization anti-HBs serology (Hepatitis B surface antibody) attached

<table>
<thead>
<tr>
<th>DATE vaccine (Year/Month/Day)</th>
<th>Vaccine type and dose</th>
<th>HCP Initials</th>
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   Either HB (Recombivax, Engerix) or HAHB (Twinrix) vaccine may be given to start or continue a series (3-dose schedule preferred).

   Give one booster vaccine if not immune after the primary vaccination series (anti-HBs < 10 IU/L).

7. **Influenza:** Annual immunization with seasonal influenza vaccine (usually available mid-October).

8. **TB Continuing Surveillance:** For details, click on: [TB Risk Assessment & TST Conversion](#).

COMPLETE THIS BOX FOR THE FOLLOWING PROGRAMS ONLY: □ Medicine □ Midwifery □ Physician Assistant

9. **Blood borne viruses:** HBsAg (Hepatitis B surface antigen), HIV, and Hepatitis C (HCV) serology, dated after March 1st this year. HCP to document only the DATES of the tests and provide the student with a copy of the reports. Note, HBsAg (ANTIGEN) and anti-HBs (ANTIBODY) are different tests; HBsAg tests for chronic Hepatitis B infection and anti-HBs tests for immunity. Do not have a test for HBsAg serology within 28 days after a Hepatitis B vaccine to avoid the possibility of a false positive result.

   **N.B. Students must SELF-REPORT any positive test results to the Assistant/Associate Dean of their program.**

<table>
<thead>
<tr>
<th>HBsAg DATE of test (Year/Month/Day)</th>
<th>Report given to student</th>
<th>HCP Initials</th>
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<tr>
<td>HCV</td>
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</table>

   Report for HBsAg must be attached

   Do not attach report

   Do not attach report
SECTION E: COMPLETE THIS SECTION FOR THE FOLLOWING PROGRAM ONLY: ☐ Medicine

Submit this page with your form by July 15th.

10. Clerkship Visiting Electives Health Screening:

    Currently, students at most medical schools must submit health screening documentation with their applications for clerkship electives at other Canadian Universities, specifically the AFMC Student Portal Immunization and Testing Form.

    McMaster University is participating in a “home school verification” process. Students who have met basic requirements defined by the Association of Faculties of Medicine of Canada (AFMC) are verified by the Health Screening Office and may not need to submit the AFMC Form. Note that students who are fully cleared on their Year One Health Screening Record are meeting the requirements. The Health Screening Office notifies students individually whether they are verified and completes the AFMC Form for students if required.

    Since this verification process involves sharing personal health information, permission from students to participate is required in advance.

    Please answer the following question with either a YES or NO:

    “I agree to permit McMaster University to confirm with any Canadian medical school to which I have applied for a clerkship elective that I am meeting basic health screening requirements defined by AFMC.”

    ☐ Yes ☐ No

    Student name (last): __________________________________________  (first): __________________________________________

    Signature: __________________________________________  Date: __________________________________________