MD Program
UNIVERSITY OF TORONTO

Returning Student Immunization Form

Deadline: Please submit the completed form online, using **ShareFile**, by **August 28, 2023**.

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 Appendix A; the remainder of the form is to be completed by the HCP. Close family members and postgraduate residents must not complete the form. Submit the completed form and any attachments according to the instructions on the MD Program's Registration Requirements & Requests page.

Guidelines Document: For additional details, refer to the COFM Immunization Policy.

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 the administrative and student service offices at the Temerty Faculty of Medicine to:
   a. administer my enrollment and program-related activities in the University of Toronto Doctor of Medicine Program, and
   b. ensure that I meet its health standards or the ones of the relevant health authorities or clinical sites.
2. I give my consent that the information on this form may be shared with university/hospital teaching and administrative staff in appropriate cases.
3. I acknowledge that to the best of my knowledge the personal health information provided in this form is completely accurate.
4. I have not completed any part of this form myself, with the exceptions of this section and (if applicable) Appendix A. 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 four items.

Last Name: _____	**Given Name(s):** _____
Student Number: _____	**Year of Study:** ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Signature: _____	**Date (yyyy-mm-dd):** _____

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. The item(s) documented must be within the HCP's scope of practice. Dates are to be in the format "yyyy-mm-dd". HCPs signing below acknowledge they are not signing a form a student has previously completed.

Name: _____ **Profession:** _____ **Initials:** _____

Address: _____

Tel: _____ **Fax:** _____

Signature: _____ **Date (yyyy-mm-dd):** _____

SECTION C: TUBERCULIN TEST

1. **TB History:** Does the student have ANY of the following: a previous history of a positive tuberculin skin test (TST); a clear history of blistering TST reaction; a positive interferon gamma release assay (IGRA) test; a previous diagnosis of TB disease or TB infection; a history of treatment for TB disease or infection?

   ☐ **Yes** – The student should not have a repeat TST. Go to Appendix A.

   ☐ **No** – Proceed to Questions 2-4.

2. **Most Recent TST:** For returning students without a positive TB history, documentation of a one-step TST within 12 months of the 2023-2024 academic year start date is required.

	Date Given (yyyy-mm-dd)	Date Read (yyyy-mm-dd)	Millimeters of Induration	Interpretation according to Canadian TB Standards[1]	HCP Initials
Recent TST					

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

3. **Provide responses** to the following three statements regarding the student's experiences since admission to medical school:

   ☐ **Yes** ☐ **No** The student had significant[1] exposure to an individual diagnosed with infectious TB disease

   ☐ **Yes** ☐ **No** The student spent time in a clinical setting with high risk of exposure to infectious TB (e.g., international electives)

   ☐ **Yes** ☐ **No** The student lived or worked in an area of the world with high TB incidence[2]

   If "**Yes**" applies to the student on one or more of these three statements, the student must complete the *Tuberculosis Awareness, and Signs and Symptoms Self-Declaration Form* **(**Appendix A**).**

4. **Chest X-ray:** If a student has a positive TST documented or any other positive TB history, the student must have a chest X ray dated subsequent to the positive TST or other positive TB history. A routine repeat or recent chest X-ray is not required unless there is a medical indication (e.g., symptoms of possible TB disease).

   Chest X-ray required?

   ☐ **Yes** – Attach the report
   (Or letter from a TB physician specialist or TB clinic report describing the film)

   ☐ **No**

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

[1] 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.

[2] For a definition of high incidence countries refer to "*AFMC Student Portal Immunization and Testing Guidelines*" (https://afmcstudentportal.ca/immunization).

SECTION D: NOVEL CORONAVIRUS DISEASE 2019 (COVID-19)

In addition to the other required vaccinations, we are requiring information on COVID-19 vaccination status. This is consistent with the COFM Guidelines, in the interests of preventing and reducing the transmission of COVID-19 at a hospital or other placement site, and to satisfy possible requirements for COVID-19 vaccination status information by specific hospitals or other placement sites. For these purposes, and consistent with both the COFM Guidelines and the provincial approach to immunization policies more generally, we are requiring proof of vaccination of each dose of COVID-19 vaccine (of a two-dose COVID-19 vaccination series approved by Health Canada).

Dose 1 vaccination date (yyyy-mm-dd): _____ HCP Initials: _____

Dose 2 vaccination date (yyyy-mm-dd): _____ HCP Initials: _____

Dose 3 vaccination date (yyyy-mm-dd): _____ **(OPTIONAL)** HCP Initials: _____

Dose 4 vaccination date (yyyy-mm-dd): _____ **(OPTIONAL)** HCP Initials: _____

You may alternatively submit a proof of your COVID-19 vaccination (your vaccination receipt which is issued to you at the time of your vaccination) along with this immunization form.

Exemption Request:

- ☐ I am requesting an exemption from the COVID-19 vaccination due to a medical reason that is consistent with the Ontario's Ministry of Heath's Medical Exemption Guidance.
- ☐ I understand that I will be contacted directly with information on the University of Toronto process and required information prior to my placement start date.

If you are unable to satisfy this requirement, please contact Hana Lee, Director, Enrolment Services & Faculty Registrar, at 1 King's College Circle, Toronto, Ontario, M5S 1A8 or registrar.medicine@utoronto.ca.

SECTION E: INFLUENZA

An up-to-date seasonal influenza immunization is required. If vaccine is not currently available, document the immunization once vaccine becomes available (typically mid-October) and resubmit this updated form online.

Annual influenza vaccine date (yyyy-mm-dd): _____ HCP Initials: _____

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

Note: If this appendix is not needed, please do not submit this page with the immunization 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 C**)

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)

_____

_____

Last Name: _____ Given Name(s): _____

Signature: _____ Date (yyyy-mm-dd): _____

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Appendix B: Explanation of Radiographic Findings

Note: If this appendix is not needed, please do not submit this page with the immunization form.

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 report, with the chest X-ray report attached (alternatively it is acceptable to attach a letter or form from a physician, tuberculosis clinic, or other specialized clinic covering the following items).

☐ ***Chest X-ray report attached.***

Name of student: _____

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: _____

Address: _____ Tel: _____

Signature: _____ Date (yyyy-mm-dd): _____