# Authorization for Health Surveillance & Immunization

HTH SCI 3H03/4F03/4A09/4B06/4D03/4W03

## STUDENT INFORMATION

**STUDENT NAME:**

**STUDENT NUMBER:**

**COURSE NAME & NUMBER:**

**DATE:**

**Notice of Collection**

The information gathered on this form is collected under the authority of *The McMaster University Act, 1976*. The information is used for the academic, administrative, and statistical purposes of the Faculty of Health Sciences BHSc Program including, but not limited to, maintaining records; academic counselling and the administration of examinations. Personal student information provided on this form will not be used for any unrelated purpose without the consent of the student. This information is protected and is being collected pursuant to section 39(2) and section 42 of the *Freedom of Information and Protection of Privacy Act* of Ontario (RSO 1990). Questions regarding the collection or use of this personal information should be directed to the Associate or Assistant Dean, Faculty of Health Sciences BHSc Program, Room MDCL 3308, McMaster University.

## BHSc (Honours) Program Authorization

________________________________ __________________________

**Authorized by one of the following:** **Date**

**Del Harnish, Assistant Dean**
**Teresa Basilio, Program Administrator**
**Andrea Phair, Curriculum Assistant/Student Advisor**

Once you have completed the, **Authorization for Health Surveillance and Immunization Form**, please return the form to the BHSc Office for approval/authorization.

- Once the form is authorized, you must schedule an appointment with Student Health Services for Health Surveillance and Immunization at (905) 525-9140 ext. 27700 (or your Family Physician). If it is your first time to Student Health Services (MUSC-B101), you must schedule an appointment with a physician. If you have been a patient at Student Health Services, you need to schedule an appointment with a nurse for the Health Surveillance and Immunization.

**You MUST take the following three pieces of information with you to Student Health Services at the time of the appointment**:

1. Authorization for Health Surveillance and Immunization Form (approved by the BHSc Office)
2. Communicable Disease Screening Protocol (to be completed by Student Health Services)
3. Please note that you MUST have your immunization records with you **prior** to the appointment with Student Health Services. You may obtain this information from your Family Physician or the Public Health Unit in your area. The addresses and phone numbers for Public Health Units in Ontario may be accessed on the web at: http://www.alphaweb.org/index.asp, select Public Health Units in Ontario. Once you have completed your Health Surveillance and Immunization, please ensure that Student Health Services authorizes the Communicable Disease Screening Protocol. YOU MUST return the forms to the BHSc (Honours) Program Office for our records.

Communicable disease screening can take longer than one month to complete as some vaccines are spaced 4 weeks apart - please leave yourself adequate time. Students are not permitted to start the clinical placement until the requirements have been met. Many clinical sites will require a copy of the completed form.

Once the Health Surveillance and Immunization has been completed, a **$20.00** charge will be made to your student account.

**Health Surveillance and Immunization will be required on an annual basis if you have patient contact for a BHSc course.**

***IF YOU ARE HAVING YOUR IMMUNIZATIONS COMPLETED THROUGH YOUR FAMILY DOCTOR, PG. 1 OF THIS FORM IS NOT REQUIRED.**

Form completed by:
Family Doctor ❑
Student Health Services ❑

# COMMUNICABLE DISEASE SCREENING PROTOCOL

Please document all dates as ***day/month/year*** and complete all **3** pages of this form

Last Name: ________________________ First Name: ___________________ Middle Initial: ____
Student #:___ ___ ___ ___ ___ ___ ___ Date of Birth: ________________________
Education Program: ___________________________ Sex: Male____ Female____
Hamilton/McMaster Phone #____________________Home Phone #______________________

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| DISEASE | REQUIRED | Health Care Providers: Please DO NOT sign until requirements met ! |
|---|---|---|
| | **(Please select one of the following options for TB screening and sign 1 grey section to the right)**<br>**Reminder - BCG is not a contraindication for TB skin testing**<br>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _<br>****5 mm or more is considered positive for those infected with HIV, those who are recent close contacts of a patient with active TB and those who have chest x-ray findings consistent with healed TB.**<br>**10 mm or more is considered positive for all others.** | |
| Tuberculosis | **Option #1:**<br>**Known History of Positive TB Skin Test.**<br>Chest x-rays should be taken on individuals who have:<br>(a) never been evaluated for a positive Mantoux skin test or for TB;<br>(b) had a previous diagnosis of TB but have never received adequate treatment for TB or;<br>(c) pulmonary symptoms that may be due to TB<br>Positive Skin Test (date):_______________________mm induration____<br>Date of last Chest X-ray:_________________________ | ____________________<br>(print name)<br>____________________<br>(signature)<br>**OR** |
| Tuberculosis | **Option # 2:**<br>**2 step TB skin testing is required. Provide documentation of previous two step TB skin test , if not available, do current 2 step TB skin test.**<br>Step One (date)___________ mm induration____ (date read)__________<br>Step Two (date)___________ mm induration____(date read)___________<br>(*ideally given within 1-3 weeks of Step 1)*<br>If the 2 step above was completed in the past 12 months, continue with next section. If completed longer ago than 12 months, do single TB skin test & document below:<br>Current/Annual TB skin test is required.<br>TB skin test (date) __________mm induration_____ (date read)__________<br>TB skin test (date)__________ mm induration_____ (date read)__________<br>TB skin test (date)__________ mm induration_____ (date read)__________<br>TB skin test (date)__________ mm induration_____ (date read)________<br>TB skin test (date)__________ mm induration_____ (date read)__________ | ____________________<br>(print name)<br>____________________<br>(signature)<br>**AND**<br>Signature (1/year)<br>____________________<br>____________________<br>____________________<br>____________________<br>____________________ |

| DISEASE | **Recommended**<br>The following are recommended only and do not require signatures. | |
|---|---|---|
| Tetanus<br>Diphtheria<br>Polio | Td is recommended every 10 years. A Polio booster should also be considered (TdP) due to uncertainty of clinical placement/travel.<br><br>Td (date)____________ **OR** TdP (date)____________ | |
| Flu Vaccine | Flu Vaccine is recommended for health science students on an annual basis. This may be a requirement in many clinical settings. Please do not document vaccines given more than 12 months ago.<br><br>Flu Vaccine (date)________________ Flu Vaccine (date)________________<br><br>Flu Vaccine (date)________________ Flu Vaccine (date)________________ | |

| DISEASE | **REQUIRED**<br>(3 signatures required in grey section to the right) | **Health Care Providers: Please DO NOT sign until requirements met !** |
|---|---|---|
| Rubella | Rubella or MMR Vaccine on or after first birthday<br>Vaccine _____________________ (date)<br>**OR**<br>Blood test for rubella antibody:<br>Result:______________________ (date)_____________<br>If result "non-immune", give MMR Vaccine<br>Vaccine Name:____________________(date)______________ | ____________________<br>(print name)<br><br>____________________<br>(signature) |
| Measles | **If born 1970 or earlier, consider immune and no further testing required.**<br>If born after 1970, 2 doses of measles vaccine required or a positive titre.<br>1st dose of Measles Vaccine or MMR on or after first birthday<br>Vaccine Name: ___________________(date)___________<br>**AND**<br>2nd dose of Measles Vaccine or MMR:<br>Vaccine Name:____________________ (date)___________<br>**OR**<br>Blood test for measles antibody:<br>Result:_____________________ (date)___________<br>If result "non-immune", give MMR Vaccine<br>Vaccine Name:____________________ (date)____________ | ____________________<br>(print name)<br><br>____________________<br>(signature) |
| Varicella | History of chicken pox or shingles (date)____________<br>**OR**<br>Blood test for varicella antibody:<br>Result:______________________ (date)____________<br>**AND/OR**<br>If negative history of disease &/or negative titre, two doses of varicella vaccine are required (vaccine cost to be paid by the student)<br><br>Dose 1 (date)____________ + Dose 2 (date)____________ | ____________________<br>(print name)<br><br>____________________<br>(signature) |

| | | |
|---|---|---|
| **DISEASE** | **REQUIRED**<br>(1 signature only required in grey section) | **Health Care Providers: Please do not sign until requirements are met !** |
| Hepatitis B | Hepatitis B Vaccine x 3 doses (*Health Care Provider may sign as completed after dose 2 so that student may start clinical placement*)<br><br>Dose 1 (date)____________<br><br>Dose 2 (date)____________<br><br>Dose 3 (date)____________<br>**AND**<br>Blood test for Hep B surface antibody (minimum 3 months after Dose 3):<br>Result:___________________ (date) ______________<br>- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -<br>If result non-immune and 1st series given *in past 5 years*, repeat series x 3 doses<br><br>Dose 4 (date)____________<br><br>Dose 5 (date)____________<br><br>Dose 6 (date)____________<br>**AND**<br>Blood test for Hep B surface antibody (minimum 3 months after Dose 6)<br>Result:___________________ (date) ______________<br>**NOTE: Maximum dose = 6 Hep B Vaccines**<br>- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -<br>If result from 1st series non-immune and first series was given *more than 5 years ago*, give one dose (dose 4) and record above. Repeat blood test 1 month after dose 4.<br><br>Result:___________________ (date) ______________<br><br>If result is non-immune after dose 4, complete second series (dose 5 & 6). Repeat blood test minimum 3 months after dose 6 and record below.<br><br>Result:___________________ (date) ______________ | ____________________<br>(print name)<br><br>____________________<br>(signature)<br><br>- - - - - - - - - - - - - - - - - - - -<br><br>____________________<br>(print name)<br><br>____________________<br>(signature)<br><br>- - - - - - - - - - - - - - - - - - - -<br><br>____________________<br>(print name)<br><br>____________________<br>(signature) |

| DISEASE | REQUIRED<br>(3 signatures required in grey section to the right) | Health Care Providers: Please DO NOT sign until requirements met ! |
|---|---|---|
| Rubella | Rubella or MMR Vaccine on or after first birthday<br>Vaccine ______________________ (date)<br>**OR**<br>Blood test for rubella antibody:<br>Result:_______________________ (date)_____________<br>If result “non-immune”, give MMR Vaccine<br>Vaccine Name:_____________________(date)_______________ | ______________________<br>(print name)<br>______________________<br>(signature) |
| Measles | **If born 1970 or earlier, consider immune and no further testing required.**<br>If born after 1970, 2 doses of measles vaccine required or a positive titre.<br>1st dose of Measles Vaccine or MMR on or after first birthday<br>Vaccine Name: ____________________(date)____________<br>**AND**<br>2nd dose of Measles Vaccine or MMR:<br>Vaccine Name:_____________________ (date)____________<br>**OR**<br>Blood test for measles antibody:<br>Result:______________________ (date)____________<br>If result “non-immune”, give MMR Vaccine<br>Vaccine Name:_____________________ (date)_____________ | ______________________<br>(print name)<br>______________________<br>(signature) |
| Varicella | History of chicken pox or shingles (date)_____________<br>**OR**<br>Blood test for varicella antibody:<br>Result:_______________________ (date)_____________<br>**AND/OR**<br>If negative history of disease &/or negative titre, two doses of varicella vaccine are required (vaccine cost to be paid by the student)<br><br>Dose 1 (date)_____________ + Dose 2 (date)_____________ | ______________________<br>(print name)<br>______________________<br>(signature) |
| | | |

| DISEASE | REQUIRED<br>(1 signature only required in grey section) | Health Care Providers: Please do not sign until requirements are met ! |
|---|---|---|

| | | |
|---|---|---|
| Hepatitis B | Hepatitis B Vaccine x 3 doses (*Health Care Provider may sign as completed after dose 2 so that student may start clinical placement*)<br><br>Dose 1 (date)____________<br><br>Dose 2 (date)____________<br><br>Dose 3 (date)____________<br>**AND**<br>Blood test for Hep B surface antibody (minimum 3 months after Dose 3):<br>Result:___________________ (date) ______________ | ____________________<br>(print name)<br><br>____________________<br>(signature) |
| | If result non-immune and 1st series given *in past 5 years*, repeat series x 3 doses<br><br>Dose 4 (date)____________<br><br>Dose 5 (date)____________<br><br>Dose 6 (date)____________<br>**AND**<br>Blood test for Hep B surface antibody (minimum 3 months after Dose 6)<br>Result:___________________ (date) ______________<br>**NOTE: Maximum dose = 6 Hep B Vaccines** | ____________________<br>(print name)<br><br>____________________<br>(signature) |
| | If result from 1st series non-immune and first series was given *more than 5 years ago*, give one dose (dose 4) and record above. Repeat blood test 1 month after dose 4.<br><br>Result:___________________ (date) ______________<br><br>If result is non-immune after dose 4, complete second series (dose 5 & 6). Repeat blood test minimum 3 months after dose 6 and record below.<br><br>Result:___________________ (date) ______________ | ____________________<br>(print name)<br><br>____________________<br>(signature) |

*SECTION BELOW FOR ADMINISTRATIVE PURPOSES ONLY*

| Yr 1 Clearance (date)_____________ | Yr 2 Clearance (date)_____________ | Yr 3 Clearance (date)_____________ | Yr 4 Clearance (date)_____________ |
|---|---|---|---|
| CHC stamp | CHC stamp | CHC stamp | CHC stamp |

Please use back of this page to document Clearance beyond Year 4.