



IMMUNIZATION RECORD

McGill University and McGill University Teaching Hospitals

Please Print Clearly

Personal Information

Last name:		First name(s):			
No. & Street:		City-Province:		Postal Code	
Date of birth (yy/mm/dd):		Student or resident #:		Admission year 20____	
Medicare Card no.	Province:	Expiry date:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Tel #:	1-Home in Montreal	2- Cellular	3- Pager		
E-mail:			International student / fellow <input type="checkbox"/> yes <input type="checkbox"/> no		
Check the appropriate box.	Medicine / Dentistry:				
	<input type="checkbox"/> Undergraduate medicine (student)		<input type="checkbox"/> Undergraduate dentistry (student)		
<input type="checkbox"/> Graduate medicine (resident / fellow)		<input type="checkbox"/> Other: _____			

Authorization for Disclosure of Information: I understand that it is my responsibility to inform the appropriate personnel of any communicable disease, special need or medical condition which may place me at risk or pose a risk to others during clinical placements. The information on the Immunization form will be kept confidential within my clinical site. However, under the following circumstances and for the duration of the program, I authorize the release of this immunization record to: 1. The clinical site personnel where an occupational exposure occurs; 2. The treating medical site/institution (if required); 3. Another clinical placement site (if requested).

Signature of Student

Date

Policy for Student/Resident/Fellow Placements

Physicians/Nurses have an obligation to protect patients and themselves from infections that can be transmitted within health care practice settings. Immunization is an important tool in preventing the transmission of infections and assists in safeguarding the health of the individual during their education and beyond:

1. The University of McGill has mandated immunization/testing requirements for all students doing clinical practice in the city of Montreal agencies and in designated agencies of other regions.
2. These agencies have reserved the right to refuse access to students who do not meet their immunization/testing requirements.
3. Failure to submit a signed and correctly completed immunization form by the due date to the appropriate individual will result in barring the individual from starting clinical training and/or withholding of salary until the immunization requirements are satisfactorily fulfilled.

It is the individual's responsibility to ensure the following:

1. The form is complete, legible and signed by the individual and authorized Physicians/Nurses. Copy made for personal records.
2. Copies of ORIGINAL immunization records are attached along with all required serology reports/results and chest x-ray report (if needed due to positive Mantoux results). These documents can take several weeks to obtain.
3. Medical exemption is attached if necessary (**no personal exemptions will be accepted**).

Designated Offices (to return completed forms)

- MUHC Adult: Ms. Sonya Panzera, Royal Victoria Hospital, 687 Pine Ave. W., Room F9.51, Montreal, QC H3A 1A1
- MUHC Peds: Ms. Josee Warda, Montreal Children's Hospital, 2300 Tupper St., Room F-256, Montreal, QC H3H 1P3
- Sir MBD Jewish General Hospital: Ms. Marilyn Dascal, Jewish General Hospital, 3755 Cote Ste. Catherine, Montreal, QC H3T 1E2
- St. Mary's Hospital: Ms. Ornella Cosentino, St. Mary's Hospital, 3830 Lacombe, Montreal, QC H3T 1M5
- CSSS de Gatineau: Ms. Geneviève Fleurant-Chef, CSSS de Gatineau, 500 boul. de l'Hôpital, suite 100, Gatineau, QC J8V 2P5

IMMUNIZATION RECORD

NAME (Last, First): _____ DATE OF BIRTH (y/m/d) _____

ATTACH COPIES OF YOUR VACCINATION RECORDS

TETANUS / DIPHTHERIA

Primary series is complete: Record attached **OR** No record available (fill in below)

Last booster dose: Vaccine: _____ Date: _____ Signature of HCP _____

Adult primary series of 3 doses is required if there are no records.

	Date	Vaccine	HCP Signature
Dose #1			
Dose #2 1-2 mos. after 1 st dose			
Dose #3 6-12 mos. after 2nd dose			

PERTUSSIS (dTap, Adacel, Boostrix)

One dose of pertussis vaccine (after age 14) is required -> Record attached **OR** No record available (fill in below)

	Date	Vaccine	HCP Signature
Dose			

POLIO

Primary series is complete: Record attached **OR** No record available (fill in below)

Last booster dose: Vaccine: _____ Date: _____ Signature of HCP _____

Adult primary series of 3 doses is required if there are no records:

	Date	Vaccine	HCP Signature
Dose #1			
Dose #2 1-2 mos. after 1 st dose			
Dose #3 6-12 mos. after 2nd dose			

VARICELLA (CHICKEN POX)

Varicella serology is required **for everyone**: Serology results -> attached. If serology negative, vaccination proof required (fill in below)

Adult primary series of 2 doses is required if serology is negative and no evidence of previous vaccination

	Date	Vaccine	HCP Signature
Dose #1			
Dose #2 1 month after 1 st dose			

MEASLES, MUMPS AND RUBELLA (MMR)

Record attached **OR** No record available (fill in below)

Proof of immunity requires at least **TWO** measles and **TWO** mumps-containing vaccines
and
at least **ONE** vaccine containing rubella (regardless of serology results).

	Date	Vaccine	HCP Signature
Dose #1			
Dose #2			

IMMUNIZATION RECORD

NAME (Last, First): _____ DATE OF BIRTH (y/m/d) _____

ATTACH COPIES OF YOUR VACCINATION RECORDS

HEPATITIS B

Primary series **is complete**: Records attached **AND** Serology for Anti-HepBsAg (i.e. HepBsAb) results -> attached

→ If serology results show less than 10iu/ml, refer to **Section A**, indicate "Booster Dose", and perform serology 2-4 weeks later.

→ If serology results show greater than 10iu/ml, no further action required due to adequate immunity.

Primary series **is not complete** or records are **unavailable**:

→ Serology for HepBsAb ("surface antibody") **AND** HepBsAg ("surface antigen") -> attached

Proceed with the following directions according to the serology results, and indicate which situation applies (check box):

HBsAb < 10iu/ml AND HBsAg Undetected → Vaccinate with full series (record in **Section A**); do serology 2-4 weeks after last dose.

HBsAb < 10iu/ml AND HBsAg Detected → Consult Health Services.

HBsAb > 10iu/ml AND HBsAg Undetected → Immune. No further action is required.

Section A:

1.	Booster Dose?	Date	Vaccine	HCP Signature
Dose #1	Yes / No			
Dose #2	Yes / No			
Dose #3				
Dose #4 Accelerated sched.				

TUBERCULIN SKIN TEST (Mandatory on year of admission; one-step skin test annually thereafter and after any TB exposure)

Previous **positive** Mantoux test or treated TB: If you have a **documented** previously positive TB test (PPD/Mantoux) (induration ≥ 10 mm)

OR a history of treated TB, then a TB skin test is NOT REQUIRED. However, you must show proof of that test result **AND** a chest X-ray report from the time of the positive test or following the TB treatment (or more recently) **AND** sign the following statement:

I certify that I do not currently have, nor have I had in the past month, ANY of the following: persistent cough ≥ 4 weeks, hemoptysis (blood in sputum), fever of ≥ 7 days (≥ 38°C), night sweats ≥ 7 days duration, or a recent diagnosis (within past 6 months) of active TB.

My situation is (check one): POSITIVE skin test (proof attached) **OR** Previous TB disease (treated)

Signature _____ Date (dd/mm/yy) _____

→ INH prophylaxis taken? YES Indicate duration and dates of INH treatment: _____

NO State reason: _____

→ TB therapy: state drugs and dates: _____

Previously negative 2-step PPD within past year: attach proof of PPD results, No PPD required at this time.

Previously negative 2-step PPD at any other time: attach proof of PPD results, perform PPD once now; record results below.

Previously negative 1-step PPD more than 1 year ago: attach proof of PPD result, perform 2-step PPD now; record results below.

Previously negative 1-step PPD within past 1 year: attach proof of PPD result, perform PPD once now; record results below

No proof of any PPD results: perform 2-step PPD now; record results below

PPD #1 Date planted: _____ Date read: _____ **Result** _____ (mm induration). _____ RN/MD

PPD #2 Date planted: _____ Date read: _____ **Result** _____ (mm induration). _____ RN/MD

Attesting Signatures of Physician/Nurse (Please include: Physician/Nurse Name, Clinic Contact information and signature)

Stamp:	Stamp:
Signature:	Signature:

REQUIREMENTS IMMUNIZATION RECORD

To: Physician/Nurse

Thank you for your cooperation with the immunization process for this individual. For the protection of patients and health-care workers, individuals are expected to provide documentation of immunization or immunity. Immunization requirements, listed below for each section for each section of the form, follow the standards outlined in the Protocole d'immunization du Québec and/or National Advisory Committee on Immunization guidelines.

General instructions:

1. Copies of available OFFICIAL vaccination records and required serology results must be attached to the immunization form.
2. The completion of the immunization form must be by a Health Care Provider who is under the authority of a Physician or Medical Officer of Health.
3. Initials and a signature are required in the event that there are several HCP completing sections of the form. There are spaces to sign and an attesting signature and address is required at the end of the form.
4. Health Care establishments have reserved the right to refuse access to individuals who do not meet their immunization testing requirements and the University has therefore established the requirements based on a wide range of expectations.
5. The University's immunization requirements are not subject to accommodations for philosophical reasons and only a medical exemption can be accepted.
6. Any decision by the HCP that impedes the individual in fulfilling the requirements will only delay and complicate the process for the individual. Failure to submit a signed and correctly completed immunization form to the designated office will result in banning the individual from clinical activities and withholding of salary until all requirements are fulfilled.

Specific requirements:

Tetanus and Diphtheria

1. Proof of primary series is mandatory.
2. If proof is not provided, vaccination with a 3 dose series is required and must be recorded.
3. Date of last booster is required and must have been received within 10 years from anticipated year of graduation.

Pertussis

1. Documented proof of at least one dose after the age of 14 is required. (dTap-Adacel)

Polio

1. Proof of primary series is mandatory. If proof is not provided, vaccination with a 3 dose series is required and must be recorded.

Varicella (Chicken Pox)

1. Proof of immunization or adequate antibody titre indicative of immunity. A history of illness is NOT satisfactory proof of immunity.
2. If titre is non-reactive or equivocal, adequate vaccination must have been administered and recorded.

Measles, Mumps, Rubella (MMR)

There must be documented receipt of **two** doses of measles and mumps, containing vaccine.

If Serology is performed (optional), and results are negative to one or more of any of these three viruses, vaccination with trivalent vaccine (MMR) is required and must be recorded.

REQUIREMENTS IMMUNIZATION RECORD (continued)

Hepatitis B

1. Proof of vaccination must be attached or recorded and **post vaccine serology for Hepatitis B Surface Antibody must be attached**. If serology results show less than 10iu/ml, revaccinate with a booster dose, record dates of vaccination AND recheck for Surface Antibody 2-4 weeks post vaccination. If serology results indicate Surface Antibody greater than 10iu/ml then no further action is required.

2. If official records are unavailable for proof of vaccination, serology for Surface Antibody AND Surface Antigen is required and must be attached. The following is required based on serology results:

HBsAb <10iu/ml AND HBsAg Undetected → Vaccinate with series of Hepatitis B or Hepatitis AB combined, record dates of vaccination, attach serology results with adequate Antibody response (>10iu/ml) 2 to 4 weeks post-vaccination.

HBsAb < 10iu/ml AND HBsAg Detected → Consult Health Services.

HBsAb > 10iu/ml AND HBsAg Undetected → Immune. No further action is required

Two Step Tuberculin Skin Test - Mantoux Screening

1. TB skin testing is required upon entry to the program regardless of previous BCG vaccination history, unless proof of a previous positive skin test or proof of treated TB is provided.
2. Mantoux screening must be completed prior to any live vaccine such as MMR, OPV or Varicella.
3. Previously tested individuals with a documented positive result (induration \geq 10 mm) or those who received TB therapy for active disease, should not receive any TB skin tests.
5. A chest X-Ray report is required for previously tested positive students. The chest x-ray must have been done at the time of the skin test positivity (or more recently) or at the end of TB treatment. The report must be attached to the form and will be valid for the duration of studies at the University.
6. Positive Mantoux results: The individual is responsible for reporting any possible signs and symptoms of active TB.
7. After the initial two-step test, only a one step Mantoux is required yearly for the duration of the program and after any TB exposure.
8. If there is an interval greater than 12 months between annual TB skin tests, then the Two Step process needs to be redone.

Influenza

1. Yearly vaccination is highly encouraged. The most current vaccine is available by October or November of every year.

Meningococcus

Individuals who are routinely exposed to *N. meningitidis* in a laboratory setting should be immunized with the conjugate quadrivalent vaccine (A, C, Y and W-135) (Menactra). At the present time, this includes only laboratory technologists, microbiology residents / fellows, and infectious diseases residents / fellows. This vaccination will be done at the hospital sites.

Comments or questions from student to Physician/Nurse: