Health Screening Record: Entry Level
Due: August 1st MWF 150 Entry Year

Student name: _____

(Rev. June 2017)

MIDWIFERY EDUCATION PROGRAM HEALTH SCREENING REQUIREMENTS

1. **Hepatitis B**: Primary vaccination series (3 vaccines 0, 1 and 6 months apart), plus serologic proof of immunity (Anti-HBs ≥ 10 IU/L) ≥ 1 month after primary series complete. Vaccine series may be in progress during MWF 150 entry year if two vaccines are complete and vaccine #3 with serologic testing for immunity is complete in accord with standard immunization schedule. Evidence of vaccine #3 with serologic proof of immunity is due with submission of placement requirements prior to entry to MWF 120. If no proof of immunity after completion of two primary series, student to verify awareness and education of non-responder status.
2. **Measles, Mumps, Rubella & Varicella**: Two vaccinations at least four weeks apart after 12 months of age (one Rubella vaccine is acceptable) - OR - serologic proof of immunity (IgG antibody).
3. **Tuberculosis (TB)**:
   No previous positive tuberculosis skin test (TST): Negative two-step TST, plus additional negative single TST if two-step test more than six months prior to deadline (February 1st), plus subsequent annual single TST, plus negative one-step TST post exposure if required.
   Positive TST or IGRA serology: Negative chest x-ray subsequent to positive test, plus no symptoms of active TB disease, plus verification of assessment and education of positive result, plus annual verification of no symptoms of active TB disease.
4. **Adult Pertussis**: One dose of pertussis vaccine age 18 years or older.
5. **Tetanus, Diphtheria & Polio**: Primary vaccination series (3 vaccines 0, 1 and 6 months apart), plus tetanus diphtheria booster in last 10 years if required. Vaccine series may be in progress during MWF 150 entry year if two vaccines are complete by deadline and vaccine #3 is complete in accord with standard immunization schedule. Evidence of vaccine #3 is due with submission of placement requirements prior to entry to MWF 120.
6. **Influenza**: Annual influenza immunization is not required by the Midwifery Education Program (MEP), but may be required by the practice site where students are placed for placements occurring between November and June. Student to provide proof of immunization directly to placement site as required.

GENERAL INSTRUCTIONS TO STUDENT

a. Print pages 1-5 to be completed by an appropriate health care provider (HCP) within their scope of practice. Your childhood immunization record will be helpful to your HCP, if available.
b. Complete the student declaration on page 5 and any relevant appendices.
c. Exemptions to health screening requirements are allowed for documented medical reasons only, in which case documentation by a physician is required.
d. Ensure all sections of the form, relevant appendices are complete and all required reports as indicated are attached.
e. Submit the form by the deadline with all required supporting documentation to the MEP in a **complete** package.
f. Keep originals of all documents in case they are required during your clinical placement. **Health screening documents submitted to the MEP are not returned.**
g. Completion of this Record is mandatory to participate in clinical activities. If placement requirements are incomplete by the deadline for submission, entry to clinical activities will be delayed. Placement dates may be extended or successful completion of the course may be compromised.
h. All health screening documentation must be cleared by MEP before students may attend clinical activities.

The Ryerson MEP health screening requirements are in accord with the Ontario Hospital Association (OHA) Communicable Diseases Surveillance Protocols, the Canadian Immunization Guide for Health Care Workers, and the Council of Ontario Faculties of Medicine.

Personal information provided on this Record and supporting documents are protected and are being collected pursuant to the Freedom of Information and Protections of Privacy Act of Ontario (RSO 1990). This information will be held in strict confidence by the Midwifery Education Program and is only disclosed as needed with the consent of the student. For any questions about the collection, use or disclosure of this information by the Midwifery Education Program, please contact the MEP office at (416) 979-5104.

Ryerson University

Health Screening Record: Entry Level
Due: August 1st MWF 150 Entry Year

Student name: _____

Health Care Provider Information

Health Care Provider (1)

Name: _____ Profession: _____ Initials: _____

Address: _____

Email: _____ Phone: _____

Signature: _____ Date: _____

Health Care Provider (2)

Name: _____ Profession: _____ Initials: _____

Address: _____

Email: _____ Phone: _____

Signature: _____ Date: _____

Health Care Provider (3)

Name: _____ Profession: _____ Initials: _____

Address: _____

Email: _____ Phone: _____

Signature: _____ Date: _____

Exceptions and Contraindications to Vaccination and Testing Requirements

Is the student unable to meet any of the requirements listed in this document due to a medical condition?

☐ No, a medical condition is not present that prevents the student from meeting vaccination or testing requirements

☐ Yes, a medical condition is present that prevents the student from meeting vaccination or testing requirements

Please provide details below - OR - ☐ Relevant information attached

Details:

The student must also complete and attach *Appendix A: Exceptions and Contraindications to Vaccination and Testing Requirements Self Declaration Form.*

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Hepatitis B

Document Hepatitis B vaccinations, record serologic testing for antibodies to HBsAg (anti-HBs) for evidence of immunity and attach laboratory reports for anti-HBs.

1. Vaccination series (Do not vaccinate if the student is Hepatitis B surface antigen positive)

Document a three dose primary vaccination series. If starting a new primary series, a three-dose schedule (0, 1, 6 months) is recommended over a rapid four-dose schedule. (Note that Recombivax administration at ages 11-14 requires only a two-dose schedule.) If a primary vaccination series is in progress, vaccine 1 and 2 must be administered and documented and the student must complete and attach *Appendix B: Completion of Primary Vaccination Series*.

	Date	Vaccine name (if known)	HCP initials
Vaccine 1:			
Vaccine 2:			
Vaccine 3:			
Vaccine 4 (if required):			
Vaccine 5 (if required):			
Vaccine 6 (if required):			

2. Serology (attach reports)

Document serologic testing for immunity (anti-HBs) one or more months after primary vaccination series is complete and attach laboratory report.

Immune: anti-HBs ≥ 10 IU/L

Non-immune: anti-HBs < 10 IU/L. If more than six months since completion of primary series, give one booster dose and repeat anti-HBs one month later. If repeat anti-HBs is not immune, give two additional doses of the vaccine five months apart and repeat anti-HBs one month later. If between one and six months since primary series complete, give second primary vaccination series (0, 1, 6 months) and repeat anti-HBs one month later.

Non-responder: If anti-HBs < 10 IU/L after two primary series, the student is considered to be a vaccine non-responder and should complete *Appendix C: Hepatitis B Vaccine Non-Responders Self-Declaration Form*.

	Test date	Laboratory result	Interpretation (immune or non-immune)	HCP initials
anti-HBs				

Measles, Mumps, Rubella and Varicella

Document **one** of the following for evidence of immunity for each infectious disease:

1. Two doses of live vaccine given 28 days or more apart, with the first dose after 12 months of age. One dose of live vaccine is acceptable for rubella - OR -
2. Positive serology for IgG antibodies (records to be attached) - OR -
3. Laboratory evidence of infection (records to be attached)

Note that tuberculin skin tests must be given **before** or at least four weeks **after** live vaccines (MMR, Varicella).

1. Vaccinations

If a primary vaccination series is in progress, vaccine 1 and 2 must be administered and documented and the student must complete and attach *Appendix B: Completion of Primary Vaccination Series*.

	Date vaccine 1	Date vaccine 2	HCP initials
Measles:			
Mumps:			
Rubella:			
Varicella			

- OR - 2. Serology (attach reports)

The preferred approach for students with no record of measles, mumps or rubella is to immunize without testing for immunity. For students with no record of varicella vaccinations, the preferred approach is to test for varicella serology.

Post-vaccination serology should **not** be done following vaccination requirements in #1 above.

Laboratory reports must be attached for serologic proof of immunity.

	Test date	Lab result	Interpretation (immune or non-immune)	HCP initials
Measles:				
Mumps:				
Rubella:				
Varicella				

- OR - 3. Laboratory Evidence of Infection (attach reports)

Laboratory evidence of infection (e.g. isolation of virus, detection of deoxyribonucleic acid or ribonucleic acid or seroconversion) to measles, mumps, rubella or varicella meets the requirement for evidence of immunity.

Laboratory reports must be attached for laboratory evidence of immunity.

Name of test	Test date	Laboratory results	HCP initials

Tuberculosis (TB)

1. Past TB History

Do any of the following apply to the student?

☐ Yes ☐ No Documented positive tuberculin skin test (TST) (record result in #2 below), positive blistering TST reaction (attach record), and/or positive interferon gamma release assay (IGRA) test (attach report).

☐ Yes ☐ No Previous diagnosis and/or treatment for TB disease or TB infection.

If 'Yes' applies to the student on either of these two questions, the student must complete and attach *Appendix C: Tuberculosis Awareness and Signs and Symptoms Self-Declaration Form*. These students should not have a repeat TST; skip to #4 below.

2. Tuberculin Skin Tests (TSTs)

If 'No' applies to the student to both questions in #1 above, document a two-step TST given at any time in the past (two separate tests, ideally 7-28 days apart but may be up to 12 months apart.). In addition, if the negative two-step TST was completed before February 1st in current calendar year, additional single TST is required.

TSTs must be given **before** or at least four weeks **after** live vaccines (MMR, Varicella).

Previous Bacillus Calmette-Guérin (BCG) vaccination and pregnancy are not contraindications to tuberculin skin testing.

	Date TST	Date read	mm Induration	HCP initials
Step 1:				
Step 2:				
Additional TST if required				

3. Recent TB Exposure

Has the student had any of the following since admission to midwifery school?

☐ Yes ☐ No Significant exposure to an individual diagnosed with infectious TB disease.

☐ Yes ☐ No Previous diagnosis and/or treatment for TB disease or TB infection.

If 'Yes' applies to the student on either of these two questions, the student must complete and attach *Appendix D: Tuberculosis Awareness and Signs and Symptoms Self-Declaration Form*. These students should not have a repeat TST; skip to #4 below.

4. Chest X-ray (attach report)

If the student has a positive TST (documented in #2 above) or any other positive TB history, the student must submit a chest X-ray report. The chest X-ray must be performed subsequent to the positive TST or positive TB history.

The HCP must also confirm that no signs or symptoms of active disease are present. If any abnormalities on the chest X-ray report or physical exam are noted, documentation from the physician explaining the findings is required.

Chest X-ray date	Chest X-ray result	HCP assessment	HCP initials
	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	

Pertussis

Document a one-time acellular pertussis containing vaccination (Tdap or Tdap-IPV) given at age 18 years or older. The type of vaccine must be known. If this information is no longer available, repeat the vaccination.

Date	Type of vaccine used	Age received	HCP initials

Tetanus, Diphtheria and Polio

Document the last three tetanus, diphtheria and polio containing vaccinations (minimum one month between first two doses of a series and minimum six months between last two doses). Last tetanus/diphtheria vaccination must be within the past 10 years. If a primary vaccination series is in progress, vaccine 1 and 2 must be administered and documented and the student must complete and attach *Appendix B: Completion of Primary Vaccination Series*.

	Date Td	Date Polio	HCP initials
Vaccine 1:			
Vaccine 2:			
Vaccine 3:			

Seasonal Influenza Vaccine

The MEP recommends a seasonal influenza vaccine by December 1 for placements occurring between November and June. This is not mandatory unless required by a clinical practice setting where the student is placed. If an influenza outbreak occurs in the assigned practice setting, the placement will be interrupted for students without current vaccination. Placement dates may be delayed or extended and successful completion of the course could be compromised.

Student Declaration

My signature below indicates the following:

- I understand that the personal health information provided in this form will be kept confidential and will be used by the MEP for purposes of participation in clinical activities to ensure I meet the health standards of the program and clinical settings.
- I understand that I am responsible for any costs associated with health screening requirements.
- I understand that additional health screening may be required in clinical settings where I am placed and that I will be responsible to provide documentation directly to the placement site.

Last name: _____ First name: _____

Date of birth: _____ Ryerson ID: _____

Signature: _____ Date: _____

Appendix A:
Exceptions and Contraindications to Vaccinations and Testing Self Declaration Form

Appendix A applies only to students who are unable to meet any of the requirements listed in the Health Screening Record due to a medical condition documented by their physician on page 1 of this record. Only these students are required to complete and submit this appendix with the Health Screening Record.

My signature below indicates the following:

- I acknowledge that I may be inadequately protected against the following infectious disease(s):
  - _____
  - _____
- I acknowledge that in the event of a possible exposure that passive immunization or chemoprophylaxis may be offered to me for the infectious disease(s) listed above where appropriate.
- I acknowledge that in the event of an outbreak of the infectious disease(s) listed above that I may be withdrawn from clinical activities for the duration of the outbreak.
- I acknowledge that my placement may be delayed or extended if I am withdrawn from clinical activities.
- I acknowledge that I may be required to take additional precautions to prevent transmission, such as wearing a surgical mask.

_____
Student name

_____
Signature

_____
Date

Appendix B:
Completion of Primary Vaccination Series

Appendix B only applies to students whose primary vaccination series for tetanus and diphtheria and/or hepatitis B is in progress. Only these students are required to complete and submit this appendix with the Health Screening Record.

Two of the three vaccines in a primary series must be administered by the deadline and the third vaccine must be administered according to the standard vaccination schedule. The third vaccine must be documented by the student's health care provided on the *Placement Requirements Record: Returning Students* by the deadline for the entry year to MWF 120 Normal Childbearing. Students requiring dose 3 for Hepatitis must also provide evidence of immunity by serologic testing for anti-HBs.

My signature below indicates the following:

- I acknowledge that I may be inadequately protected against the following infectious disease(s):
  - _____
  - _____
- I acknowledge I am required to complete dose #3 of the primary vaccination series in accord with the standard vaccination schedule.
- I acknowledge that I am required to document dose #3 for the primary series in progress on the Placement Requirements Record: Returning Students by the deadline for the entry year to MWF 120 Normal Childbearing, in addition to serologic testing for anti-HBs where relevant.
- I acknowledge that in the event of a possible exposure that passive immunization or chemoprophylaxis may be offered to me for the infectious disease(s) listed above where appropriate.
- I acknowledge that in the event of an outbreak of the infectious disease(s) listed above that I may be withdrawn from clinical activities for the duration of the outbreak.
- I acknowledge that my placement may be delayed or extended if I am withdrawn from clinical activities.

_____
Student name

_____
Signature

_____
Date

Appendix C:
Hepatitis B Vaccine Non-Responders Self Declaration Form

Appendix C only applies to students who have received two primary vaccination series for hepatitis B and post-vaccination serology does not demonstrate immunity (anti-HBs < 10 IU/L). Only these students are required to complete and submit this appendix with the Health Screening Record.

It is important that students ensure that each vaccination was documented, all doses were administered with appropriate spacing (0, 1, 6 months) and post-vaccination serology was conducted between 28 days and six months after the final dose of the series. No further pre-exposure hepatitis B vaccinations or serology testing are required following two primary vaccination series.

My signature below indicates the following:

- I acknowledge there is no laboratory evidence that I am immune to hepatitis B.
- I acknowledge that in the event of a possible exposure to hepatitis B (e.g. percutaneous injury or mucosal splash) that passive immunization with hepatitis B immune globulin may be required.

_____
Student name

_____
Signature

_____
Date

Appendix D:
Tuberculosis Awareness and Signs and Symptoms Self Declaration Form

Appendix D applies only to students who have one or more of the following:

- Positive tuberculin skin test
- Positive interferon gamma release assay blood test
- Previous diagnosis and/or treatment for tuberculosis (TB) disease
- Previous diagnosis and/or treatment for TB infection
- Significant exposure to infectious TB disease

Only these students are required to complete and submit this appendix with the Health Screening Record.

My signature below indicates the following:

- I have received medical assessment and education for a positive result or history related to tuberculosis
- I will report any symptoms of possible TB disease to my health care provider, including:
    - persistent cough lasting three or more weeks
    - bloody sputum
    - shortness of breath
    - chest pain
    - night sweats
    - fever
    - chills
    - unexplained weight loss

_____
Student name

_____
Signature

_____
Date