MD Program
UNIVERSITY OF TORONTO

Returning Student Immunization Form

Deadline: Please submit the completed form online, using ShareFile, by **August 27, 2018**.

- **Upload to this ShareFile folder:** https://utmed.sharefile.com/r-r0b7d04af49d4dea8
- **Save your file as:** "Class – LastName, FirstName – Immunization – 2018" (e.g. 2T1 – Smith, Mary – Immunization – 2018)

Notice of Collection

The University of Toronto respects your privacy. The personal information provided on this form will be used by the administrative and student service offices at the Faculty of Medicine to administer your enrolment and program-related activities in the University of Toronto Doctor of Medicine Program.

The personal information provided on this form will only be used and protected in accordance with the Freedom of Information and Protection of Privacy Act. If you have any questions about this policy and/or ShareFile, please contact Janet Hunter, Director of Enrolment Services & Faculty Registrar, at 1 King's College Circle, Toronto, Ontario, M5S 1A8 or registrar.medicine@utoronto.ca.

SECTION 1 - STUDENT INFORMATION

Student Number:	**Year of Study:** ☐ 2nd ☐ 3rd ☐ 4th
Last Name:	**First Name:**

SECTION 2 - TUBERCULIN TEST

No further testing is required if your TB test result from the previous academic year was positive.

Test Date (yyyy-mm-dd): _____	Results: ☐ Negative ☐ Positive*	Reading (mm of Redness & Induration): _____
Date of last known negative (yyyy-mm-dd): _____	Previous BCG vaccination: ☐ Yes ☐ No Previous Treatment for TB: ☐ Yes ☐ No	Date of BGD (yyyy-mm-dd): _____

***If test results are positive, a chest x-ray will be required. All students who test positive must contact the Office of Health Professions Student Affairs (OHPSA) at ohpsa.admin@utoronto.ca.**

CHEST X-RAY Date (yyyy-mm-dd): _____ Results: ☐ Normal ☐ Abnormal

SECTION 3 – SEROLOGICAL STATUS (obtained within 12 months of the start date of the academic year)

Students must retain copies of their serology results, as we may request the original copy.

1. HEPATITIS B

Lab Evidence of Immunity (**anti-HBs higher than 10 IU/L):** ☐ Immune (+) ☐ Non-immune (-) Date: _____ (yyyy-mm-dd)

2. HEPATITIS C

Titre: ☐ Reactive ☐ Non-Reactive Date: _____ (yyyy-mm-dd)

3. HUMAN IMMUNODEFICIENCY VIRUS (HIV)

Titre: ☐ Reactive ☐ Non-Reactive Date: _____ (yyyy-mm-dd)

SECTION 4 - TRAINEE AUTHORIZATION

I give my consent that the information on this form may be shared with university/hospital teaching and administrative staff in appropriate cases.

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

SECTION 5 - CLINIC/HEALTH CENTRE AUTHORIZATION

I certify that the above information is complete and accurate:

_____
(name, address, and phone number of clinic/health care centre/hospital where the form was completed)

Signature of health care professional: _____ **Date:** _____
(yyyy-mm-dd)