Health Screening Record: MWF 150 Entry Year **Student name:** _____
Submission Deadline to Synergy Gateway: September 1
Verification Deadline by MEP: September 7

The Toronto Metropolitan University MEP health screening requirements meet the standards 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.

Student Instructions

- ☐ Print pages 1-4 to be completed by a health care provider (HCP) with the authority to document this information within their scope of practice.
- ☐ Complete the Student Declaration below and relevant appendices. Do not complete any other sections of the Record.
- ☐ Present your childhood/adult immunization record(s) and COVID vaccine receipt(s) to your HCP for review. If you do not have your immunization records, contact your past HCP or the local public health unit that serviced your elementary/high school.
- ☐ Where past records are not available, new vaccine series will be required, except for Measles, Mumps, Rubella and/or Varicella if serologic proof of immunity is documented.
- ☐ Ensure all sections of the form and relevant appendices are complete and all required reports are attached, including your immunization record and COVID receipt(s) if your HCP did not record the vaccine information on this form.
- ☐ Exemptions to health screening requirements are allowed only for documented medical reasons, which must documentation by the HCP.
- ☐ Submit all forms with all supporting documentation to Synergy Gateway by September 1 for verification by the MEP by September 7.
- ☐ Keep original copies of this Record and supporting documents in case they are required during a clinical placement.
- ☐ Vaccine series in progress must be documented and verified by Synergy Gateway by the vaccine spacing timelines in the Canadian Immunization Guide.

Student Declaration

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 Synergy Gateway on behalf of the MEP 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 at (416) 979-5104.

My signature below indicates the following:

- I understand that the personal health information provided on 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.
- I understand that if any of the health screening requirements are not verified and/or lapse that my participation in clinical activities will be delayed or cancelled, and that my success in the course may be compromised.

Last name: _____ First name: _____

Date of Birth: _____ TMU ID: _____

Signature: _____ Date: _____

Midwifery Education Program
288 Church Street, DCC-676
Toronto ON M5B 1Z5

Tel: (416) 979-5104
Fax: (416) 979-5271
midwiferyplacements@torontomu.ca

Health Screening Record: MWF 150 Entry Year (June 2025) **Student name:** _____
Submission Deadline to Synergy Gateway: September 1
Verification Deadline by MEP: September 7

Health Care Provider (1)	
Name: _____ Profession: _____ Initials: _____ Signature: _____ Date: _____	Office stamp or Address/Telephone
Health Care Provider (2)	
Name: _____ Profession: _____ Initials: _____ Signature: _____ Date: _____	Office stamp or Address/Telephone
Health Care Provider (3)	
Name: _____ Profession: _____ Initials: _____ Signature: _____ Date: _____	Office stamp or Address/Telephone

Exceptions/Contraindications to Vaccination and Testing Requirements

Is the student unable to meet any of the requirements listed in this Record due to 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.

If 'Yes', attach supporting documentation **-OR-** provide an explanation below:

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

Tuberculosis: tuberculin skin tests -OR- HCP assessment and chest x-ray if positive TST/TB history

1. Tuberculin Skin Tests (skip to 2. below if student has positive TB history)

Document a baseline two-step TST from any time in the past (two separate tests given ideally 7 to 28 days apart but may be up to 12 months apart with each result read after 2-3 days, requiring 4 visits to the HCP) **-AND-** additional single (one-step) given after March 1st of this year if not already included in the two-step test. **Note**: TST must be given before or at least 28 days after a live vaccine (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	MM/DD/YYYY	MM/DD/YYYY		
Step 2	MM/DD/YYYY	MM/DD/YYYY		
Additional one-step TST (if required)	MM/DD/YYYY	MM/DD/YYYY		

-OR-

2. Positive TST or Positive TB History - HCP Assessment and Chest x-ray (attach report)

Complete only if positive TST documented in 1. above or other positive TB history:

☐ Chest x-ray report attached.

Does the student currently have any symptoms of active TB disease (persistent cough or fever lasting three or more weeks, hemoptysis, night sweats, unexplained or involuntary weight loss)?

☐ Yes ☐ No - letter from physician is required

The student must also complete and attach *Appendix D: Tuberculosis Awareness and Signs and Symptoms Self-Declaration* Form.

Pertussis: vaccination age 18 or older

Document a one-time acellular pertussis vaccine age 18 or older, even if not due for a booster. The type of vaccine must be known. If this information is no longer available, repeat vaccination.

Date	Vaccine type (required)	Age received	HCP initials
MM/DD/YYYY			

Tetanus, Diphtheria and Polio: primary vaccination series -WITH- one tetanus vaccine within last 10 years

Document the last three vaccines that meet minimum spacing requirements (one or more months between the first two doses, six or more months between the last two doses). The last tetanus vaccine must be within the last 10 years. If the last tetanus vaccine is not within the last 10 years, provide a booster. If the student does not have documentation of past vaccinations, complete a new primary series.

If a primary vaccination series is in progress, vaccines 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
Dose 1	MM/DD/YYYY	MM/DD/YYYY	
Dose 2	MM/DD/YYYY	MM/DD/YYYY	
Dose 3	MM/DD/YYYY	MM/DD/YYYY	
Booster in last 10 years (if required)	MM/DD/YYYY	MM/DD/YYYY	

Measles, Mumps, Rubella and Varicella: 1-/2-dose vaccination series -OR- positive IgG antibody serology

Note that tuberculin skin tests must be given **before** or at least 28 days **after** live vaccines.

Document two measles vaccines, two mumps vaccines, one rubella vaccine and two varicella vaccines, given at age 12 months or older **-OR-** Positive IgG antibody serology. **Note:** MMR and varicella vaccines must either be given at the same time or spaced at least 28 days apart. Vaccines only preferred for MMR, although positive IgG antibody serology will be accepted. Varicella IgG antibody serology recommended only if no previous vaccines. For any requirement where a student does not have documented vaccines or serologic immunity, initiate a new vaccine series.

	Date vaccine 1	Date vaccine 2		IgG antibody report attached	HCP initials
Measles	MM/DD/YYYY	MM/DD/YYYY	**-OR-**	☐	
Mumps	MM/DD/YYYY	MM/DD/YYYY	**-OR-**	☐	
Rubella	MM/DD/YYYY		**-OR-**	☐	
Varicella	MM/DD/YYYY	MM/DD/YYYY	**-OR-**	☐	

COVID-19: primary vaccination series

Document a primary vaccination series for COVID-19 according to the current Canadian Immunization Guide. The student must provide COVID-19 vaccination receipts.

Dose 1 date	Dose 1 vaccine type	Dose 2 date, if given	Dose 2 vaccine type	HCP initials
MM/DD/YYYY		MM/DD/YYYY		

Hepatitis B: 3-dose primary vaccination series -AND- anti-HBs serology

1. Primary Vaccination Series

Document a primary vaccination series at age-appropriate schedule and doses (unless a history of naturally acquired infection or chronic infection is documented). An alternative 2-dose adolescent schedule will be accepted if given at ages 11 to < 16 with 10 µg Recombivax or 20 µg Engerix-B per dose. If previous vaccine records are missing or incomplete, a documented 3-dose series must be completed. All documented vaccines count towards the series as long as minimum spacing requirements are met. If a primary vaccination series is in progress, vaccines 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/dose (if known)	HCP initials
Vaccine 1	MM/DD/YYYY		
Vaccine 2	MM/DD/YYYY		
Vaccine 3 (if required)	MM/DD/YYYY		
Vaccine 4 (if required)	MM/DD/YYYY		
Vaccine 5 (if required)	MM/DD/YYYY		
Vaccine 6 (if required)	MM/DD/YYYY		

- AND -

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.

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	MM/DD/YYYY			

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.

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/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. Documentation of the third vaccine must be completed by the vaccine spacing timelines in the Canadian Immunization Guide. Students requiring dose 3 for hepatitis B 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 all doses of the primary vaccination series in accord with the standard vaccination schedule.
- I acknowledge that I am required to submit documentation dose 3 of the primary series in progress by the vaccine spacing timelines in the Canadian Immunization Guide, 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

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