Immune Status Consent Form

Rady Faculty of Health Sciences Immunization Program, University of Manitoba

Please read this document carefully, and be sure you understand it completely before signing below.

For the purposes of this document, "immune status" refers to the immunizations and testing that are required of students by the Rady Faculty of Health Sciences Immunization Program, University of Manitoba, in order to support the policies of the student's current program of study. This includes immunizations and/or testing related to diphtheria, hepatitis A and B, influenza, measles, mumps, rubella, pertussis, polio, tetanus, tuberculosis, and varicella (chickenpox). Other agents of disease may be included as outlined in (3) below.

(1) I understand that maintaining an accurate and up-to-date immune status record is an important responsibility of being a student, to protect my own health, as well as the health of the patients with whose care I will be involved.

(2) While I understand that in general immunizations and health screening tests are voluntary procedures, I acknowledge that the procedures within the scope of this document are also a condition of enrolment within my chosen program of study. At any time I may refuse any part of the proposed immunizations or testing, and I understand that this may mean I may not be allowed to participate in clinical activities involving patients, which may affect my ability to complete my program.

(3) I understand that on occasion immune status recommendations or requirements may change based on new information and evidence, outbreaks of communicable diseases, or university policies. I accept that it is my responsibility to follow through on immune status recommendations or requirements of the faculty while I am enrolled as a student.

(4) I understand that my immune status personal health information will only be used by those directly involved with the Rady Faculty of Health Sciences Immunization Program and my current program of study, and only for the stated purposes of the program; this may include designated individuals directly involved with the delivery of immunizations or screening tests, at the discretion of the Director of Immunization, Immunization Program. I understand that only the minimal amount of information required to deliver the program will be used.

(5) I consent that if required, the Immunization Program may obtain and use from an external source records of immunizations, testing, or treatment of infectious diseases that fall within the scope of this document. An external source includes but is not limited to my family physician, public health, specialty care, healthcare institutions, laboratories, and immunization registries.

(6) I give permission for all or part of my immune status record to be used by or disclosed to the occupational health departments of the facilities in which I will study as a student, at the discretion of the Director of Immunization, Immunization Program, so long as I remain a student within the faculty.

(7) If additional testing for or treatment of a communicable disease within the scope of this document is conducted by occupational health or infection control of a healthcare institution, or by public health or another institution in the community, I agree that this information may be requested and used by the Immunization Program, so long as I remain a student within my current program of study.

(8) I understand that I can request a copy of my immune status record for my own records at any time, for as long as the Immunization Program maintains a copy of my records.

(9) I understand that my immune status record will be kept secure while I am a student enrolled within my current program of study, and for a minimum of 10 years after my expected date of graduation. Eventually the Immunization Program will destroy my immune status record in a secure and confidential manner, consistent with accepted methods of disposal of health records.

_____	_____
Student Signature	Program of Study
_____	_____
Student Name (please print)	Date

Student Information

Rady Faculty of Health Sciences Immunization Program, University of Manitoba

(PLEASE PRINT NEATLY)

<table>
<tr><td colspan="2">Last name:</td><td colspan="3">Given name(s): (underline preference)</td></tr>
<tr><td colspan="2">Program of study:
☐ Dentistry ☐ Occupational Therapy
☐ Dentistry (Graduate) ☐ Pharmacy
☐ Dental Hygiene ☐ Physical Therapy
☐ Genetic Counselling ☐ Physician Assistant Studies
☐ Medicine ☐ Respiratory Therapy</td><td>Expected year of graduation:</td><td colspan="2">Have you been enrolled in any program listed on the left in any previous year? (If yes please list name of program and year)
☐ Yes ☐ No</td></tr>
<tr><td colspan="2">Date of birth: (dd/mm/yyyy)</td><td colspan="3">Sex:
☐ Female ☐ Male ☐ Other</td></tr>
<tr><td colspan="2">Mailing address:</td><td>City/town:</td><td colspan="2">Postal code:</td></tr>
<tr><td colspan="2">6-digit MHSC number (Manitoba):</td><td colspan="3">9-digit PHIN number (Manitoba):</td></tr>
<tr><td colspan="2">Out-of-province health number (list province as well):</td><td colspan="3">Country or province of birth:</td></tr>
<tr><td colspan="5">At what ages have you lived in Manitoba? (e.g., “ages 0-5 years”, “all my life”, “never”, etc.)</td></tr>
<tr><td colspan="2">Do you plan to maintain pharmaceutical coverage through the UMSU Health and Dental Plan? ☐ Yes ☐ No ☐ Not sure</td><td colspan="3">University student number:</td></tr>
<tr><td colspan="2">Name of non-UMSU plan that will provide pharmaceutical coverage:

Relationship to cardholder: ☐ Self ☐ Spouse ☐ Dependent student</td><td>Contract number:</td><td>Group number:</td><td>Carrier number:</td></tr>
<tr><td>Telephone:</td><td colspan="2">Cell:</td><td colspan="2">Pager:</td></tr>
<tr><td colspan="5">Email:
Can we communicate personal health information to you individually through this email address? (e.g., outstanding vaccination issues or advice; email will not be given out) ☐ Yes ☐ No ☐ N/A
If yes, please provide your University of Manitoba email address (non-university accounts cannot be used):</td></tr>
<tr><td colspan="5">Person to call in case of an emergency:</td></tr>
<tr><td colspan="2">Relationship:</td><td colspan="3">Telephone:</td></tr>
</table>

Student signature: _____ **Date**: _____

Please notify the Immunization Program of any changes to the information listed above. Thank you.

Student Health Questionnaire

Rady Faculty of Health Sciences Immunization Program, University of Manitoba

Student name: _____ **Date of Birth**: _____

All students are asked to answer the following questions (1-14) about their health and immune status requirements. The information will be used (1) to ensure students meet the requirements to participate in their chosen program of study, and (2) to ensure students are provided adequate supports when necessary.

This information is kept confidential and is available to the minimal number of staff who require this information.

Students who anticipate requiring disability-related accommodation are responsible for notifying the Dean's office of their program at the time of application, and should changes occur at any time throughout their education.

Please let us know if the answers to any of the questions below change during your time as a student.

Please let us know if you have any questions: 204-480-1305, immune@umanitoba.ca

General Health Questions:

1. Do you have any allergies? ☐ Yes ☐ No If yes, please list; include symptoms or signs that occur, and their severity:

2. Do you have any restrictions on your physical activity or mobility, or any movement disorders? ☐ Yes ☐ No If yes, please describe:

3. Do you have any medical condition where you feel the faculty's knowledge of this condition may benefit your physical well-being in the event of an emergency? (e.g., severe allergy, diabetes, severe asthma, etc.) ☐ Yes ☐ No If yes, please describe in detail:

   All individuals with a medical condition that may result in a loss of consciousness or reduced ability to communicate should consider obtaining a medical bracelet or necklace; students with a severe allergy should discuss with their healthcare provider obtaining and carrying an epinephrine auto-injecting device.

4. Do you have any medical condition(s) that significantly compromise(s) your immune system? (e.g., treatment for Crohn's disease; dialysis; etc.) ☐ Yes ☐ No If yes, please describe in detail:

5. Do you have any physical or mental health condition(s), which you feel may interfere with your ability to offer safe care to patients, or which may interfere with your ability to be successful in your education? ☐ Yes ☐ No If yes, please describe in detail:

   Students should be aware that supports are available from the University of Manitoba, including Student Accessibility Services (http://umanitoba.ca/student/saa/accessibility) and the Academic Learning Centre (http://umanitoba.ca/student/academiclearning). Additionally, specific mentorship may be facilitated by your Faculty.

6. **Please note:** students in all programs must disclose to the Immunization Program if they are known to have chronic hepatitis B infection. Students in Dentistry, Dental Hygiene, Medicine, and Physician Assistant Studies known to have chronic human immunodeficiency virus (HIV) or hepatitis C infection are expected to disclose their status to their respective programs (contacts are as follows: College of Dentistry: Associate Dean, Clinical; Max Rady College of Medicine including Physician Assistant Studies: Associate Dean, Student Affairs).

   Students in all programs will be offered optional, free testing for HIV and/or hepatitis C in the fall, and have the option of receiving free testing at any time throughout their studies.

Student name: _____ **Date of Birth**: _____

Background and Immune Status Requirements:

Questions 7-11 relate to the following vaccine-preventable diseases:

- Tetanus
- Diphtheria
- Pertussis
- Polio
- Measles
- Mumps
- Rubella
- Varicella
- Hepatitis A and hepatitis B

7. Where did you receive any of your childhood immunizations, usually given at ages 0 to 16 years? (Check all that apply)

- ☐ Likely in Manitoba before 1982 (We will obtain a provincial immunization registry record on you; you do not need to do this, **however you may also need to search for childhood records that were not entered into the registry**)
- ☐ Likely in Manitoba in or after 1982 (We will obtain a provincial immunization registry record on you; you do not need to do this)
- ☐ Likely in another province or country (**Please obtain these records and submit them to the Immunization Program.** If records are not in English you can still submit these.)
- ☐ Other (give details):

We will be requesting records for students from the provincial immunization registry (please see **page 5** of the Student Manual for a description of this). However, if you know of any relevant immunization records that you feel are not likely captured by the provincial immunization registry, please submit these to the program for review.

8. Have you ever had chickenpox disease or shingles? (Check all that apply; see **page 20** of the Student Manual)

- ☐ Yes, I am absolutely certain, I had chickenpox at (provide a precise age and/or year) _____
- ☐ Yes, I had shingles (zoster) at (provide a precise age and/or year) _____
- ☐ I had a very mild form of chickenpox disease, or I am not certain
- ☐ I was vaccinated against chickenpox
- ☐ No, I don't think I had chickenpox ever in my life

Students may wish to check with their parents or former caregivers regarding the answer to this question.

9. Have you ever had serology checked for chickenpox (varicella) antibodies?

- ☐ Yes (**please obtain these records and submit them to the Immunization Program**)
- ☐ No, I did not
- ☐ I am not certain

10. Have you ever had immunizations, tuberculin skin tests, and/or serology tests performed to satisfy the occupational health requirements of another program, school, or employer (e.g., employment or volunteering at a hospital)?

- ☐ Yes (**please obtain these records and submit them to the Immunization Program**)
- ☐ No
- ☐ I am not certain

11. This section relates to **hepatitis A, hepatitis B**, and **hepatitis A+B** ("*Twinrix*") vaccines (see **pages 21-24** of the Student Manual).

Previous vaccinations: Have you ever had any doses of hepatitis vaccine? (Check all that apply)

- ☐ I have had _____ doses of plain hepatitis **A** vaccine
- ☐ I have had _____ doses of plain hepatitis **B** vaccine
- ☐ I have had _____ doses of combined hepatitis **A+B** vaccine (brand name "*Twinrix*").
- ☐ I am not certain

We will check the provincial immunization registry records for any doses that appear, and students do not need to do this. However we will let you know if doses you claim to have received do not appear in the provincial immunization registry. **Please submit to the Immunization Program documentation of any hepatitis immunizations received in another province or country.**

Current vaccine needs: We will give you an opportunity during the first-year orientation to decide through a written questionnaire which additional hepatitis immunizations, if any, you would like to receive, and where you would like to receive them.

Serology (antibodies): Have you ever had serology checked for hepatitis B antibodies, which demonstrated immunity?

- ☐ Yes (**please obtain these records and submit them to the Immunization Program**)
- ☐ No, I did not have this testing performed
- ☐ I had this testing performed, but my results showed negative antibodies (no evidence of immunity), date: _____
- ☐ I am not certain

Special situations: Please offer us any additional useful information relating to your hepatitis vaccine requirements:

Student name: _____ **Date of Birth**: _____

12. Have you ever been diagnosed with any of the following: (See **pages 25-27** of the Student Manual)

☐	Yes	☐ No	☐ Not certain	Active tuberculosis disease
☐	Yes	☐ No	☐ Not certain	Latent tuberculosis infection (LTBI)
☐	Yes	☐ No	☐ Not certain	A positive tuberculin skin test (TST or Mantoux)
☐	Yes	☐ No	☐ Not certain	A positive blood test for TB infection (interferon gamma release assays such as QuantiFERON TB Gold and T-SPOT.TB are new tests that are not widely available in Canada)

If you answered "Yes" to any of the above questions, please list all details, including the results of any follow-up measures taken:

13. Have you ever had a Bacille Calmette-Guérin (BCG) vaccination for tuberculosis? (See **page 28** of the Student Manual)

- ☐ Yes, I did at (age or date): _____, and the scar is located (area of body) _____
- ☐ No I did not
- ☐ I am not certain

Students may wish to check with their parents or former caregivers regarding the answer to this question.

14. Most students will require one or more tuberculin skin tests (TST or Mantoux test), which is offered through the Immunization Program school clinics (see **pages 25-27** of the Student Manual).

Have you had any previous TSTs or interferon gamma release assay (IGRA) blood tests performed?

- ☐ Yes (**please submit any available documentation**; note that TST and IGRA test results do not appear in the provincial immunization registry)
- ☐ No
- ☐ I am not certain

If you have documentation of previous TSTs, were any of the TSTs self-read (e.g., you read the test yourself, and then reported the result to a physician or nurse).

- ☐ Yes
- ☐ No
- ☐ I am not certain
- ☐ I do not believe I have had any TSTs

15. During the first-year orientation we will ask you through a written questionnaire where you plan to have your immunization and testing requirements completed. Options will include having all services through the school Immunization Program, or having all services through your own provider. **You do not need to decide on this right now.**

Last year 99% of first-year students opted to have services provided through the Immunization Program. For more information see **pages 1-4** of the Student Manual.

Please do not go to your provider right now for any of the items you may require. If you have already decided now that you would like to have all items addressed through your own provider (and do not want to wait for the orientation session to decide this), please phone us or send us an email (204-480-1305, immune@umanitoba.ca) and we will provide you with a letter that can be taken to your own provider listing required immunizations and tests.

Please note that parents, partners, and close family members **must not** provide students immunizations or testing, and must not complete any forms.

Student signature: _____ **Date**: _____

Please notify the Immunization Program of any changes to the information listed above. Thank you.

Notice Regarding Collection, Use, and Disclosure of Personal Information and Personal Health Information by the University

Your personal information and personal health information is being collected under the authority of *The University of Manitoba Act*. The information you provide will be used by the University for the purpose of creating a record of your immune status, and for determining your ability to participate in patient-related activities during your placement with your program of study. Your personal information and personal health information may be disclosed to your clinical placement site to confirm your immune status. Your personal information and personal health information will not be used or disclosed for other purposes, unless permitted by *The Personal Health Information Act* (PHIA) or *The Freedom of Information and Protection of Privacy Act* (FIPPA). If you have any questions about the collection of your personal information or personal health information, contact the Immunization Program (tel. 204-480-1305); you may also wish to contact the Access & Privacy Office (tel. 204-474-9462), 233 Elizabeth Dafoe Library, University of Manitoba, Winnipeg, MB, R3T 2N2.