THE UNIVERSITY OF NOTRE DAME AUSTRALIA

School of Medicine, Fremantle

Infectious Diseases screening and Immunisation requirements for Medical Students

Please take the following forms to your doctor or immunisation clinic **to be completed as a priority**. Please read each form carefully, and follow the instructions given. Unless otherwise stated all evidence must be complete at enrolment.

These forms **must** be completed by a Doctor or a Registered Immunisation Nurse working in a Health Care Facility. To avoid unnecessary testing please ensure your provider understands the importance of complying with the requirements.

See clinician guidelines sheet for more information.

Please attach copies of:

- Completed Infection Control Checklist
- Immunisation History Statement
- your HIV, Hep C serology and;
- all other relevant pathology results (MMRV, HepBsAb, QGold, MRSA).

Should you have any questions, please contact the School of Medicine Reception – (08) 9433 0228

The University of Notre Dame Australia – School of Medicine, Fremantle 2024

Infection Control Checklist- Must be completed and submitted.

Student Name:	**Student ID no:**

Dear Doctor, please refer to *Immunisation Requirements* table and accompanying note in *Infection Control Policy* for guidance.

IMMUNISATION

COVID-19 enclosed

☐ Immunisation Statement History Dr initials_____

Measles Mumps Rubella (MMR)

☐ Documented evidence of 2 doses: #1 / / #2 / /

OR

☐ There is serological evidence of immunity to all 3 diseases ☐ Copies enclosed Dr initials_____

Varicella (Chicken Pox)

☐ Documented evidence 2 doses: #1 / / #2 / /

OR

☐ Serological evidence of immunity ☐ Copy enclosed Dr initials_____

Diphtheria Tetanus Pertussis (Whooping Cough)

☐ Documented evidence of primary immunisation (4 doses)

AND

☐ evidence of vaccination within 10 years Date / / Dr initials_____

(if boosting, recommend DTPa + IPOL vaccine) **DO NOT CHECK SEROLOGY**

Polio

☐ Documented evidence of primary immunisation (4 doses) **DO NOT CHECK SEROLOGY**

Adult booster provides lifetime immunity (See DTPa above) Dr initials_____

Hepatitis A

☐ Serological evidence of immunity (If suspect completed vaccine schedule prior or had exposure) ☐ Copy enclosed

OR Documented commencement of 2 dose schedule:

☐ #1 / / #2 (≥ 6 months) / / Dr initials_____

Hepatitis B

☐ Serology test date (HBsAb > 10) / / ☐ Immune ☐ Not immune ☐ Copy enclosed

If NOT immune provide evidence of age appropriate primary immunisation and give a booster dose

Vaccination course had been sighted / commenced: #1 / / #2 / / #3 / /

+/- ☐ Booster / / +/- ☐ Serology after booster ☐ Immune ☐ Not immune ☐ Copy enclosed

Dr initials_____

SCREENING

MRSA Screening

If a student has been working or a patient in a hospital outside WA in the last 12 months screening is required

Screening required ☐ Yes ☐ No Result: ☐ Positive ☐ Negative ☐ Copy enclosed

Follow up required ☐ Yes ☐ No Dr initials_____

Tuberculosis

☐ Quantiferon Gold serology test date / / Result: ☐ Positive ☐ Negative

Follow up required ☐ Yes ☐ No ☐ Copy enclosed Dr initials_____

A positive Quantiferon Gold test requires clearance from TB Control in the relevant state.

Blood Borne Virus Serology enclosed

HIV ☐ **Hep C** ☐ ***Please forward a copy of all relevant pathology testing*** ☐ Dr initials_____

<u>This form must be signed by a Doctor or Authorised Registered Nurse (Immunisation Provider)</u>

Doctor/Registered Nurse Name:

PRACTICE STAMP

_____

Signature: _____

Health Care Agency: _____

Updated October 2023