UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

GRADUATE PROGRAM – Returning Student Immunization Form

(Returning students or students entering a degree or residency program who completed their undergraduate DDS studies at UofT since 2004)

TUBERCULIN TEST REPORT

Student Name____________________________________ Student Number________________________ Program___________________

Year of Study: ❑ Hospital resident – Hospital: ___________________
❑ 1 (ONLY if DDS or hospital residency completed at UofT since 2004 – all others must complete Incoming Grad form)
❑ 2 ❑ 3 ❑ 4 ❑ Other ____

ALL RETURNING STUDENTS must have a standard tuberculin test each year, to be forwarded to the Assistant Dean, Clinics, Room 205/206, Faculty of Dentistry, University of Toronto, 124 Edward Street, Toronto, ON M5G 1G6 or via fax to 416-979- 4767, **no less than two weeks prior to the start of their clinical program.**

CHOOSE ONE OF THE FOLLOWING OPTIONS:

❑ **OPTION 1** (for those students who tested negative for TB the last academic year attended)	❑ **OPTION 2** (for those students who have previously tested positive for TB)
Date of Tuberculin test: ______________ Results: Negative ❑ Positive ❑ Reading (induration) in mm: ______________ Date of last known negative: ______________	**I hereby certify that the health status of my patient, in reference to his/her tuberculosis status, has not changed in the past year.** ____________________________________ **Health Care Provider Signature** Please also note: Previous treatment for TB: No ❑ Yes ❑ Previous BCG Vaccination: No ❑ Yes ❑ Date of BCG ______________

COVID -19 Vaccination Dose 1 Date: ______________________ Dose 2 Date: ______________________

CHEST X-RAY: Required if above test is positive FOR THE FIRST TIME (i.e. if previous tests were negative and this is the first time the student is testing positive, a chest x-ray is required).

X-Ray Date:______________________________ Results:______________________________(or attach copy of report)
(normal or abnormal)

STUDENT 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 signed ___________________________

CLINIC/HEALTH CENTRE AUTHORIZATION:

Signature of health care professional ________________________________ Date signed ___________________________

OFFICE STAMP
(required):

Please return to:

Assistant Dean, Clinics, Faculty of Dentistry, University of Toronto, 124 Edward Street, Rm 205, Toronto, Ontario, M5G 1G6 or fax to 416-979-4767

FOR OFFICE USE ONLY: **Health Clearance**		
Approved:		Deficiencies:
Not Approved:		