**Elective Immunisation Form 1B**

**Precautions against Infectious Diseases**

**Applicants will not be permitted to undertake an elective unless the following requirements are met**

**Vaccination requirements**All students wishing to undertake electives at TCD-affiliated teaching hospitals must provide the School of Medicine with evidence of satisfactory immunity to the following infectious diseases:

* **Hepatitis B (both Surface & Core results are mandatory)**
* **Hepatitis C**
* **Pulmonary Tuberculosis**
* **Measles**
* **Mumps**
* **Rubella**
* **Chickenpox**

**Covid-19 vaccination:** all visiting students will be required to upload proof of

vaccination in their online elective application.

**Please have pages 2 to 5 completed by your Physician/ General Practitioner or University Medical Centre and submit the completed form by uploading it in the document section of your online application.**

**\*ONLY** test results from blood samples taken in the six months prior to submission of the elective application will be accepted.

**\*ALL** sections of the form must be completed in full. Incomplete documentation will not be accepted.

**Ms Rita Keane / Ms Caroline Morgan**

**International Programmes Coordinators**

**Programme Office**

**School of Medicine**

**Trinity Biomedical Sciences Institute, 152 – 160 Pearse Street**

**Dublin 2**

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**ELECTIVE APPLICANT IMMUNISATION RECORD**

Please ask your Physician/General Practitioner **to complete this medical report form** and then upload the completed form to the document section of your online elective application.

**Please note, *official lab reports and immunisation documentation must accompany this form*, we do not accept handwritten proof.**

Please complete this form using **BLOCK CAPITALS only.**

|  |  |
| --- | --- |
| Students Name: **(Surname) (First Name)** | |
| Address: | Contact Number: |
| Email-address: |
| Date of Birth : Day Month Year | |

**TB SCREENING**

|  |  |
| --- | --- |
| BCG Vaccine (submit record)  **OR**  Confirmed BCG Scar on exam  **OR**  IGRA Blood test (submit result) | Vaccination Date: YES or NO  YES or NO |

**HEPATITIS B & C STATUS** (submit results)

These tests must **ALL** be completed, regardless of whether you have previously received Hep B vaccines.

|  |  |
| --- | --- |
| Hep B surface Antigen (HBsAg) | Date: |
| Hep B core Antibody (Anti-HBc) | Date: |
| Hep C Antibody | Date: |

**MMR (MUMPS, MEASLES, RUBELLA)**

Submit 2 vaccine records

|  |  |
| --- | --- |
| Dose # 1 Vaccination Date |  |
| Dose # 2 Vaccination Date |  |

**VARICELLA (CHICKENPOX)**

|  |  |
| --- | --- |
| Varicella Zoster Vaccine (submit records)  **OR**  Varicella IgG Blood test (submit result) | Dose # 1 Vaccination Date: Dose # 2 Vaccination Date:  Date**:** |

# HEPATITIS B VACCINE

Please submit vaccine records & Hep B titre blood test (HBsAb) result.

|  |  |
| --- | --- |
| Dose # 1 Vaccination Date |  |
| Dose # 2 Vaccination Date |  |
| Dose # 3 Vaccination Date |  |
| Hepatitis B surface Antibody (HBsAb) |  |

**Doctor’s Name (Block Capitals Only)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Official Stamp of GP

**Doctor’s Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ATTACH LABORATORY RESULTS.**

TCD Office use only

I confirm that the above-named student has submitted adequate proof of immunity to undertake an elective under my supervision.

**DEPARTMENT STAMP**

TCD Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_