Clinical/Field Pre-Placement Health Form

Program Name: Child and Youth Care (St. Thomas Campus)
Program Year: Year 1
Due Date: December following September start

Program Code (#): CYW2S
Program Descriptor: Full Time

Student Information

Last Name: _____ **First Name**: _____ **Student I.D. Number**: _____
Email: _____ **Home Phone**: _____ **Cell Phone**: _____
Residential Address: _____

Bring to Your Health Care Provider Appointment

1. This form.
2. Yellow immunization card and/or regional health unit forms that denote record of your immunization history.
3. Other proof of immunization such as blood tests and/or lab results.

Hint: From your local public health unit in the area that you lived when you received high school and elementary school immunizations.

Important - Please make sure this form is completed in all of the following sections:

Section A: Mandatory Medical Requirements: to be filled out by your health care provider (Physician, Nurse Practitioner or Registered Nurse) to be completed.

Ask your health care provider to:

- Complete all of Section A.
- Complete all shaded areas.
- Provide you with proof of immunization and/or lab blood results for identified sections.
- Sign and date at the end of the section.

Section B: Other Medical Requirements: Must be completed by you, the student.
Section C: Mandatory Non-Medical Requirements: Must be completed by you, the student.
Section D: Student Agreement: Must be completed by you, the student.
Section E: Completed by the Requisite Program Nurse.

Complete the checklist on the last page to make sure you have everything before you make your appointment with the Requisite Nurse at www.requisitefanshawe.ca.

Section A: Medical Requirements – Mandatory

Instructions for Physician/Nurse Practitioner/ Registered Nurse: Please read carefully
Thank you for your cooperation with the immunization process for our student registered in this program. For the protection of students, patients and external clients, students must provide documented proof of immunization. Immunization requirements listed before each section follow the standards outlined in the Canadian Immunization Guide, Evergreen Edition, Part 4, Active Vaccines (2012), the Canadian Tuberculosis Standards (2007) and the OHA/OMA Ontario Hospitals Communicable Disease Surveillance Protocols. The required information with exact dates (yy/mm/dd) and signature for each requirement must be recorded directly on this Clinical Pre-placement Health Form in the shaded areas provided. Please also provide an attesting signature at the end of the form. Failure to complete in its entirety and submit this form by the required deadline, will exclude student from their clinical/field placement.

Please ensure you have reviewed, completed and signed the required shaded areas in Section A.

Measles Mumps and Rubella (MMR)

Instructions:
The Student must provide either a lab blood test that indicates evidence of immunity **OR** documented proof that they have received two doses of the MMR vaccine. **Copies of lab results must be provided for all three of the lab results.**

Mandatory Lab Report/Results (Attach laboratory blood report for each)

Immunity	Yes	No	Health Care Provider Initials
Measles	❑	❑	
Mumps	❑	❑	
Rubella	❑	❑	

For Requisite Nurse Only	Yes	No
Lab results provided	❑	❑
Lab results provided	❑	❑
Lab results provided	❑	❑

If Required

- MMR Vaccine Given (Dose 1): Date:_____
- MMR Vaccine Given (Dose 2): Date:_____

Note: If MMR Vaccine given, must provide proof of immunization and/or immunization health record.

For Requisite Nurse Only	Yes	No
Cleared	❑	❑
Exempt	❑	❑

Requisite

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Tuberculosis Screening

Instructions:

1. All students must have documented proof of a Two-Step TB Mantoux skin test. If proof is not available for the Two-Step Mantoux skin test or if it has not been completed previously, then the student must receive an initial Two-Step TB Mantoux skin test. The Two-Step needs to be performed **ONCE** only and it never needs to be repeated again. Any subsequent TB skin tests can be One-Step, regardless of how long it has been since the last skin test. Students who have received a BCG vaccination are **not exempt** from the initial Mantoux testing. Pregnancy is **NOT** a contraindication for performance of a Mantoux skin test.
2. Mantoux testing must be completed prior to the administration of any live vaccines (i.e. MMR, IPV) **OR** defer skin testing for 4 to 6 weeks after the vaccine is given.
3. If a student was **positive** from a previous Mantoux Two-Step skin test and/or has received TB treatment, the health care provider must complete an assessment and document below if student is free from signs and symptoms of active tuberculosis.
4. Any student who has proof of a previous **negative** Two-Step, must complete a One-Step.
5. For any student who tests positive for the first time:
   a. Include results from the positive Mantoux screening (mm of induration).
   b. A chest x-ray is required and the report must be enclosed in this package.
   c. Indicate any treatments that have been started.
   d. Complete assessment and document on form if the student is clear of signs and symptoms of active TB.
   e. The responsibility for follow up lies with the health care provider as per the OHA/OMA Communicable Disease Surveillance Protocols.

Results

Initial Two-Step Mantoux Test – Mandatory	**Date Given**	**Date Read** (48-72 hours from testing)	**Results** (Induration in mm)
One-Step			
Two-Step (7-28 days after one-step)			
Annual One-Step (If the initial Two-Step TB skin test has been completed with negative results, complete one-step only)			

Note: Must provide proof of Mantoux One-Step, Two-Step TB skin test results.

If either step is positive (10 mm or more), please evaluate the following:

1. Chest x-ray results: ❑ Positive ❑ Negative ❑ N/A Date:_____
2. History of disease? ❑ Yes ❑ No
3. Prior history of BCG Vaccination? ❑ Yes ❑ No Date:_____
4. INH prophylaxis? ❑ Yes ❑ No Dosage:_____ Duration:_____
5. Specialist referred? ❑ Yes ❑ No
6. Does this student have signs and symptoms of active TB on physical exam? ❑ Yes ❑ No

Health Care Provider Initials:_____ Date:_____

For Requisite Nurse Only	**Yes**	**No**
Chest x-ray provided	❑	❑
Cleared	❑	❑

Requisite

Varicella (Chicken Pox)

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Instructions
A lab blood test must be obtained for evidence of immunity. Copies of lab blood results must be provided. The Varicella vaccine is required if lab reports show no immunity. If a Varicella vaccine is given, repeat lab work in 6 – 8 weeks and provide a copy of the lab results (numerical values). This vaccine is not recommended (contraindicated) for pregnant women. Pregnancy should be avoided for three months after a Varicella vaccination has been given.

Mandatory Lab Report/Results (Attach laboratory blood report)
Immune to varicella? ❑ Yes ❑ No

For Requisite Nurse Use Only: Lab results provided: ❑ Yes ❑ No

If blood results indicate no immunity, provide student with varicella vaccine

- Varicella Vaccine Given (Dose 1): Date:_____
- Varicella Vaccine Given (Dose 2): Date:_____

Must provide proof of varicella immunization and/or attach immunization health record

Post vaccination lab report/results (attach laboratory blood report)
Immune to varicella? ❑ Yes ❑ No

For Requisite Nurse Use Only: Lab results provided: ❑ Yes ❑ No

Health Care Provider Initials:_____

For Requisite Nurse Only	Yes	No
Cleared	❑	❑
Exempt	❑	❑

Requisite

Tetanus/Diphtheria (Td)

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Instructions

1) Initial primary series completed with booster if more than 10 years.
2) If no previous immunization give 2 doses, 4 to 8 weeks apart.

Immunization	Yes	No	Date
Initial primary series completed	❑	❑	
Booster completed	❑	❑	
Booster given (if required)	❑	❑	

Must provide proof of tetanus/diphtheria immunization and/or attach immunization health record.

If required for primary vaccination:

- Tetanus/Diphtheria (Td) Given (Dose 1): Date:_____
- Tetanus/Diphtheria (Td) Given (Dose 2): Date:_____

Please Note: It is the student's responsibility to ensure they complete all initial primary series doses (3) for subsequent years.

Health Care Provider Initials:_____

For Requisite Nurse Only	Yes	No
Cleared	❑	❑

Pertussis

Instructions
If student has not received Pertussis vaccine they require an Adacel or equivalent vaccine (if over 18 years of age). If under 18, give initial series.

Initial immunization complete? ❑ Yes ❑ No

- If yes, provide date:_____
- If no:
  - Adacel or equivalent given: Date:_____
  - Initial series given (if under 18): Date:_____

Must provide proof of pertussis immunization and/or attach immunization health record.

Health Care Provider Initials:_____

For Requisite Nurse Only	Yes	No
Cleared	❑	❑

Polio

Instructions
Date and proof of completed initial primary series. If student has never been immunized, then give 3 doses.

Initial primary series completed? ❑ Yes ❑ No

- If no, initial primary series completed on date:_____

Must provide proof of polio immunization and/or attach immunization health record.

Health Care Provider Initials:_____

For Requisite Nurse Only	Yes	No
Cleared	❑	❑

Requisite

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Hepatitis B

Instructions

1) A lab blood test must be obtained for evidence of immunity. **Copies of lab results must be provided.**
2) If the student has documentation of a completed initial primary series and serology results are < 10 IU/L, provide a booster dose and complete another lab test 1 month following the booster. Students must provide documented proof that they have received the initial primary series for Hepatitis B vaccine.
3) If the student has not received the Hepatitis B vaccine and serology results are < 10 IU/L provide the initial primary series as follows:
    - Dose # 1 – as soon as possible.
    - Dose # 2 – one month after dose # 1.
    - Dose # 3 – six months after dose # 1.
    - **Serology is required 1 month following dose # 3.**

Mandatory Lab Report/Results

Previous initial primary series for hepatitis B completed: ❑ Yes ❑ No

- If yes, date of completion:_____
- Immune, hepatitis B: ❑ Yes ❑ No
- If not immune, provide initial primary series for hepatitis B as:
    - Hepatitis B Vaccine Given (Dose 1). Date:_____
    - Hepatitis B Vaccine Given (Dose 2). Date:_____
    - Hepatitis B Vaccine Given (Dose 3). Date:_____
        - Lab test results, post initial primary series: Immune, Hepatitis B: ❑ Yes ❑ No

Must provide proof of immunization and/or attach immunization health record. Attach laboratory blood report.

Health Care Provider Initials:_____

For Requisite Nurse Only	Yes	No	N/A
Initial lab results provided	❑	❑	
Lab results provided, post initial primary series	❑	❑	❑
Cleared	❑	❑	
Exempt	❑	❑	

To be completed by the health care provider.
Please complete the shaded area below OR provide professional identification stamp.

Signature: _____

Designation (circle one): **MD** **RN(EC)** **RN**

Initials: _____

Print Name: _____

Phone Number: _____

Stamp Area

Section B: Other Medical Requirements

Influenza: Strongly Recommended

Instructions
Influenza Vaccination (Flu Shot): Vaccine Only Available During Flu Season (October/November). All Students are encouraged to protect themselves with annual influenza immunization. Students who have not received the vaccination may be removed from clinical placement as some of our placement partners may require that students receive influenza immunization and show proof especially if there is an outbreak. **In the event of an outbreak at your placement, any student without the vaccination may be denied access to the facility thereby jeopardizing successful completion of the clinical course. Proof of flu vaccine can be scanned and emailed to ParaMed.**

Results
Seasonal flu vaccine received on date: _____
Other vaccine received: _____

Provide proof of immunization and/or immunization health record. Proof of Influenza immunization can be scanned and emailed to the Requisite Program at London@ParaMed.com.

For Requisite Nurse Only	Yes	No
Document provided	❑	❑
Cleared	❑	❑
Exception	❑	❑

For Student to Sign only when they choose to NOT receive the flu vaccine: Influenza Waiver
Students who choose not to have the annual influenza vaccine for medical or personal reasons must sign below to acknowledge their awareness of susceptibility to the disease and of the implications for clinical placement and lost time. Students must provide consent for the school to communicate their influenza immunization status to the clinical agency in which they are placed. I understand that the Academic Program encourages students to have an annual influenza vaccine. I have selected to waive this immunization based on medical and/or personal reasons. I am aware that I may be susceptible to influenza and I understand that I may not be eligible to attend clinical placement. I consent to have my program communicate my influenza status to clinical agencies.

Signature: _____

Print Name: _____

Date: _____

Section C: Mandatory Non-Medical Requirements

Instructions for Students

As a student accepted in this program, you are required to complete the following non-medical requirements.

1) Review your communication package to find out how and where to obtain these requirements.
2) Locate the approved sources to obtain the requirement(s).
3) Obtain the certificate/proof of completion.
4) For each of the non-medical requirement(s), bring the original and one copy of your certificate and/or proof of completion to your Requisite appointment.
5) Complete the shaded columns only. The last two columns are for Requisite Nurse Use Only.

If you have previously obtained one or more of the above non-medical requirements, please ensure they have not expired (if applicable).

Non-Medical Requirements	Date Issued	Expiry Date	Document Provided	Cleared
CPR Level C Certificate Card (every three years)			❑	❑
Standard First Aid (Every three years) Certificate Card			❑	❑
Vulnerable Sector Police Check (annual)			❑	❑
Placement Agreement			❑	❑

Section D: Student Agreement

Section D - The Student Agreement

I confirm that I have read this form and understand its purpose and the nature of its content. In particular, I understand that in order to comply with the Public Hospitals' Act and Ontario Hospital Association protocol, I need to demonstrate that certain health standards have been met in order for me to be granted student placement.

I understand that I must have all sections of this form fully completed and reviewed by the ParaMed Requisite Program by the identified due date. Failing to do so, may jeopardize my consideration for any student placement. All costs incurred for completion of this form are my sole responsibility.

Should it be requested, it is my responsibility to share relevant information from this form with a hospital, nursing home, or other clinical placement agency relating to my program.

Signature: _____ **Date:** _____

The personal information on this form is collected under the legal authority of the Colleges and Universities Act, R.S.O. 1980, Chapter 272, Section 5, R.R.O. 1990, Regulation 77 and the Public Hospital Act R.S.O. 1980 Chapter 410, R.S.O. 1986, Regulations 65 to 71 and in accordance with the requirements of the legal Agreement between the College and the agencies which provide clinical experience for students. The information is used to ensure the safety and well-being of students and clients in their care. The information in this form will be protected in accordance to the Freedom of Information and Protection of Individual Privacy Act.

Section E: To be completed by Requisite Nurse

Initial Visit

Pre-placement Requirement Status	Yes	No	Date	Stamp – ParaMed Requisite Office Use Only
Cleared	❑	❑		
Exception	❑	❑		
Agreement Form	❑	❑		

Nurse Signature: _____

Nurse Name (Print): _____

Date: _____

Data entered into Requisite Software by: _____

Date: _____

Subsequent Visit

Pre-placement Requirement Status	Yes	No	Date	Stamp – ParaMed Requisite Office Use Only
Cleared	❑	❑		
Exception	❑	❑		
Agreement Form	❑	❑		

Nurse Signature: _____

Nurse Name (Print): _____

Date: _____

Data entered into Requisite Software by: _____

Date: _____

Is My Clinical/Field Pre-placement Health Form Completed? – Checklist

Bring to your Requisite:

- This form.
- Blood lab reports – as required.
- Yellow immunization card or other proof of immunization (Hint: From your local public health unit in the area that you lived when you received high school and elementary school immunizations.)
- Provide photocopy of all documents.

Section A– Mandatory Medical Requirements	**Was Section A completed by the health care provider?**	**Was it signed by health care provider?**	**Do I have all the required documents attached?** (proof of immunization/blood lab report)
Measles Mumps and Rubella (MMR)	❑	❑	❑
Tuberculosis Screening	❑	❑	❑
Varicella (Chicken Pox)	❑	❑	❑
Tetanus/Diphtheria (Td)	❑	❑	❑
Pertussis	❑	❑	❑
Polio	❑	❑	❑
Hepatitis B	❑	❑	❑

Section B – Other Medical Requirements	**Did I complete all sections**	**Are the required documents attached**
Influenza immunization	❑	❑

Section C – Mandatory Non-Medical Requirements	Did I complete?	Do I have the required documents attached (certificates)?
CPR Level C Certificate Card	❑	❑
Standard First Aid	❑	❑
Vulnerable Sector Police Check	❑	❑
Placement Agreement	❑	❑

Section D – Student Agreement	Did I read, sign, and date
Student Agreement	❑