Professional Practice Health Form
School of Community Studies – Year One

Student Information

Name:_____ **Student ID:**_____

Email:_____ **Phone Number:**_____

Program Name:_____ **Year:**_____

IMPORTANT: A copy of your immunization record and any lab results must be submitted to Synergy for clearance.

Section A: To Be Completed by Health Care Provider

Health Care Provider Signature and Office Stamp

Name:_____

Signature:_____

Date (dd/mm/yy):_____

OFFICE STAMP

Tuberculosis: The student must provide proof of a two-step Tuberculosis Mantoux skin test. If there is record of a two-step TB skin test in the past, dates and results must be recorded and followed up with a one-step TB skin test (if more than 12 months have passed). Documentation of the tuberculosis skin test is required regardless of receiving the BCG vaccine. Students with a positive skin test (10mm or more in duration) must have a chest x-ray.

Two Step Tuberculosis Skin Test

Step 1: Date Given (dd/mm/yy):_____

Date Read (dd/mm/yy):_____ **Result:**_____**mm**

Step 2: Date Given (dd/mm/yy):_____

Date Read (dd/mm/yy):_____ **Result:**_____**mm**

One Step Tuberculosis Skin Test

Step 1: Date Given (dd/mm/yy):_____

Date Read (dd/mm/yy):_____ **Result:**_____**mm**

Students with a positive skin test (10mm or more in duration) must have a chest x-ray. ***A copy of the chest x-ray must be uploaded to Synergy.***

Date of x-ray (dd/mm/yy):_____ **Results:**_____

Section A: To be completed by Health Care Provider

Mumps, Measles, Rubella (MMR): Proof of immunity to Mumps, Measles and Rubella or documented proof of the 2 dose series is required. If no immunity, the student must provide proof that they have received 2 doses of the MMR vaccine.

1. **Immunity to MMR:** Evidence of immunity to Mumps, Measles and Rubella. **A copy of the lab report must be uploaded to Synergy.**

   Date blood work completed (dd/mm/yy):_____
   Mumps Immunity: ☐ Yes ☐ No **Measles Immunity:** ☐ Yes ☐ No **Rubella Immunity:** ☐ Yes ☐ No

2. **MMR Vaccine:** If no immunity, proof of 2 doses of MMR is required. **A copy of the immunization record must be uploaded to Synergy.**
   MMR Dose 1 (dd/mm/yy):_____**MMR Dose 2 (dd/mm/yy):**_____

Varicella: Proof of immunity to Varicella or documented proof of the 2 dose series is required. If no immunity, the student must provide proof that they have received 2 doses of the Varicella vaccine.

1. **Immunity to Varicella:** Evidence of immunity to Varicella. **A copy of the lab report must be Uploaded to Synergy.**
   Date blood work completed (dd/mm/yy):_____
   Varicella Immunity: ☐ Yes ☐ No

2. **Varicella Vaccine:** If no immunity, proof of 2 doses of Varicella is required. **A copy of the immunization record must be uploaded to Synergy.**
   Varicella Dose 1 (dd/mm/yy):_____**Varicella Dose 2 (dd/mm/yy):**_____

Tetanus/Diphtheria (Td) and Polio: Completion of the initial series is required with a booster if more than 10 years. If the student has not completed the initial series, 2 doses is required. **A copy of the immunization record must be uploaded to Synergy.**

1. **Tetanus/Diphtheria/Polio series completed (dd/mm/yy):**_____
   Tetanus Booster completed (dd/mm/yy): _____

2. **Tetanus/Diphtheria Dose 1 (dd/mm/yy):**_____
   Tetanus/Diphtheria Dose 2 (dd/mm/yy):_____

3. **Polio Dose 1 (dd/mm/yy):**_____
   Polio Dose 2 (dd/mm/yy):_____

Section A: To be completed by Health Care Provider

Pertussis: Students are required to provide documentation of the Pertussis vaccine. If the student has not had the Pertussis vaccine they require Adacel or equivalent (if over the age of 18). Students under 18 should receive the initial series. **A copy of the immunization record must be uploaded to Synergy.**

1. **Pertussis series complete (dd/mm/yy):**_____
2. **Dose of Adacel or equivalent (dd/mm/yy):**_____
3. **If under 18 with no history of an initial series, please provide 2 doses**
   Pertussis Dose 1 (dd/mm/yy):_____**Pertussis Dose 2 (dd/mm/yy):**_____

Hepatitis B: Proof of immunity to Hepatitis B is required. If no immunity, the student must show proof of 2 doses (minimum). **Blood work is required regardless of the immunization history.**

1. **Immunity to Hepatitis B:** Evidence of immunity to Hepatitis B. **A copy of the lab report must be uploaded to Synergy.**
   Date blood work completed (dd/mm/yy):_____
   Hepatitis B Immunity: ☐ Yes ☐ No

2. **Hepatitis B Vaccine:** If no immunity, proof of 2 doses (minimum) of Hepatitis B is required. **A copy of the immunization record must be attached.**
   Hepatitis B Dose 1 (dd/mm/yy):_____**Hepatitis B Dose 2 (dd/mm/yy):**_____
   Hepatitis B Dose 3 (dd/mm/yy):_____**Hepatitis B Booster (dd/mm/yy):**_____

Influenza: An annual seasonal flu shot is not mandatory but highly recommended. Any student without the vaccination may be in jeopardy of a successful completion of the clinical course in the event of an outbreak at your placement. The influenza vaccine is available from October to March. **Documentation of the influenza vaccine clearly indicating the date received must be uploaded to Synergy.**

Influenza Vaccine Received (dd/mm/yy):_____

COVID-19 Vaccine: This vaccine is mandatory. **Documentation of the COVID-19 vaccine clearly indicating the date received must be uploaded to Synergy**

Dose 1 received (dd/mm/yy):_____ **Dose 2 received (dd/mm/yy):**_____

Dose 3 received (dd/mm/yy):_____

Additional boosters may be required at the request of the placement agency. It is the student's responsibility to ensure they are following the agency health and safety policies.

Additional dose received (dd/mm/yy):_____

Section B: To be completed by the student

Non-Medical Requirements: The following non-medical requirements must be completed. If you have previously obtained one or more of these requirements, please verify the expiry date. If your certificate expires during the placement portion for your program, it is your responsibility to recertify within one month from the time of expiration. **A copy of all non-medical documents/certificates must be uploaded to Synergy.**

CPR – Level C Certificate (every 3 years):
Valid Certificate: ☐ Yes ☐ No **Certificate Attached:** ☐ Yes ☐ No

Standard First Aid Certificate (every 3 years):
Valid Certificate: ☐ Yes ☐ No **Certificate Attached:** ☐ Yes ☐ No

Vulnerable Sector Police Check (annual):
Valid Certificate: ☐ Yes ☐ No **Certificate Attached:** ☐ Yes ☐ No

Student Signature: _____

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 the faculty in my educational program will be able to view the results from this form. I understand that I must have all sections of this form fully completed and reviewed 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.

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.

Student Name: _____ **Student ID:** _____

Student Signature: _____ **Date (dd/mm/yy):** _____

OFFICE OF THE REGISTRAR – Room E1012
1001 Fanshawe College Boulevard, P.O. Box 7005
London, Ontario N5Y 5R6 Canada
Telephone: (519) 452-4277 Fax: (519) 452-4420

PLACEMENT AGREEMENT

Thank you for accepting our offer of admission. An essential component of your education will be experiential learning through clinical or field practice relevant to your chosen profession. In order to ensure high standards and quality educational offerings which will permit students maximum opportunities to achieve learning objectives, Fanshawe College reserves the right to place students in an agency or combination of agencies it determines to be appropriate. **While every effort is made to maximize use of local agencies, there is sometimes a need to place students outside of the area for some programs or portions of programs.**

Accordingly, your admission is subject to the condition that you must be prepared for the possibility of assignment to experiential learning outside of the area, and for the possibility of having to relocate, at your own expense, for all or a portion of this experience. You are responsible for all costs associated with Clinical and/or Field Placement, (including volunteer hours).

Please indicate your understanding and acceptance of this condition by completing ALL information and signing below.

We look forward to welcoming you as a student at Fanshawe College.

"I understand and accept the condition stated above"

STUDENT NAME (Please print): _____

STUDENT NUMBER: _____

PROGRAM: _____ **START DATE:** _____

STUDENT SIGNATURE: _____ **DATE:** _____

****IMPORTANT****

Being punctual for your placement is a major contributor to how others see you in your field. Being on time, every time, is an expectation that all students should strive to achieve.