# Professional Practice Health Form
## School of Community Studies – ECE and ECL Only

**Student Information**

**Name:** ______________________________ **Student ID:** ____________________

**Email:** ______________________________ **Phone Number:** ____________________

**Program Name:** ______________________________ **Year:** ____________

***IMPORTANT: A copy of your immunization record and any lab results must be uploaded 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**

**<u>Mumps, Measles, Rubella (MMR)</u>:** 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):** ____________

**Section A: To be completed by Health Care Provider**

**<u>Tetanus/Diphtheria (Td) and Polio (IPV)</u>:** 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):** _______________

**<u>Pertussis:</u>** 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):** ______________
   **Age of patient at the time of adult booster:** ______________
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):** __________________

**<u>COVID-19 Vaccine:</u>** This vaccine is **not mandatory** but highly recommended. **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):** ___________________

**<u>Influenza:</u>** 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):** _________________

**Section B: To be completed by the student**

**<u>Non-Medical Requirements</u>:** 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.**

**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 (every 2 years):**
**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.**