



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

Student Information

Name: _____ Student ID: _____

Program Name: _____

IMPORTANT: In addition to the completed health form, a copy of your immunization record(s) and any serology must be uploaded to Synergy for clearance. Blood work will be accepted if done within 10 years of having this form completed.

Section A: To be completed by Healthcare Provider

Health Care Provider Signature

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 Healthcare 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):** _____

Tetanus/Diphtheria/Pertussis (Tdap): Completion of the initial series is required with a Tetanus booster, if the last dose was administered more than 10 years ago. **A copy of the immunization record must be uploaded to Synergy.**

1. **Tdap series completed (dd/mm/yy):** _____

2. **Tetanus Booster completed (dd/mm/yy):** _____

If the student has not completed the initial series (or does not have record), 2 doses are required. **A copy of the immunization record must be uploaded to Synergy.**

1. **Tdap Dose 1 (dd/mm/yy):** _____

Tdap Dose 2 (dd/mm/yy): _____

Polio: Completion of the initial series is required. **A copy of the immunization record must be uploaded to Synergy.**

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

If the student has not completed the initial series (or does not have record), 2 doses are required

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

Polio Dose 2 (dd/mm/yy): _____



Section A: To be completed by Healthcare Provider

COVID-19 Vaccine: This vaccine is highly recommended but not mandatory. **Documentation of the COVID-19 vaccine clearly indicating the date received can be uploaded to Synergy.**

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

Additional vaccines 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): _____

Influenza: This vaccine is highly recommended but not mandatory. 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 Received (dd/mm/yy): _____

Section B: Non-Medical Requirements – Student Reference

Non-Medical Requirements: The following non-medical requirements must be completed. If you have already obtained any of these, please ensure they are still valid by checking the expiry dates. Any requirements set to expire during the academic year/placement period must be recertified before the due date. **A copy of all non-medical documents/certificates must be uploaded to Synergy.**

Please use the check boxes as a reference to ensure you have all of the mandatory non-medical requirements.

- | | |
|---|---|
| ☐ Standard First Aid | ☐ WSIB Declaration |
| ☐ CPR Level C | ☐ Placement Agreement |
| ☐ Vulnerable Sector Police Check | ☐ International Student Declaration, if applicable |
| ☐ Pledge of Confidentiality | |



Section C: To be completed by the student

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):** _____