

Dear Incoming Paramedic Student:

You are enrolled in a program where the completion of a **Health and Immunization Record Form for Paramedic Students is mandatory**. These standards were developed by the Ministry of Health and Long-Term Care and implemented by the Emergency Health Services Branch. Paramedic students must be free from or protected against communicable and infectious diseases while working in clinical practice and have evidence of good health. Fanshawe College has a responsibility for ensuring that each student complies with these standards.

If you are unable to find the dates of your immunization, you may be able to obtain this information from your local Public Health Unit. Contact information for all Ontario Public Health Departments can be found on the following website:

<http://www.health.gov.on.ca/english/public/contact/phu/phulocmn.html>

Vaccine or Test	Requirements
Chicken Pox (Varicella/Zoster), Measles (Red Measles), Mumps and Rubella (German Measles)	Immunization dates and blood work (serology) are mandatory for the Paramedic Program. Blood work is required to determine your immunity status. If you do not have antibody protection, immunization using the two dose schedule will be required prior to commencing clinical experience. If such immunizations are medically contraindicated, documentation must be provided. <i>(Reference : OHA/OMA Communicable Disease Surveillance Protocols #216, #218, #219 and #305)</i>
Tetanus/Diphtheria/Polio or Tetanus/Diphtheria/Pertussis (Adacel) or Tetanus/Diphtheria	Tetanus/Diphtheria "and" Polio vaccination are required every 10 years by the Ambulance Service Communicable Disease Standards . You may only require a Polio vaccination if you have had a Tetanus/Diphtheria or Tetanus/Diphtheria/Pertussis (Adacel) vaccination within the last 10 years.
Tuberculin (TB) Skin Testing (Mantoux)	Tuberculin (TB) skin testing (Mantoux) is mandatory. If you have had no testing done in the past, then a two-step TB test must be administered within 6 months prior to entry of your program. Note that 2-step testing is only required once in a lifetime. (The testing involves four visits to your doctor; two to have the test administered and two to have it read.) If you have had a prior two-step TB test done, you must provide proof of the testing and results. If your two-step TB testing date is greater than one year, an additional "one-step" TB test will also be required. The amount of induration for all tests must be measured and recorded in mm ("positive" or "negative" is not sufficient). Individuals having received a BCG vaccination in the past are still required to have a two-step skin test administered. If your test is positive, we expect your healthcare provider to follow up with you. <i>(Reference: Canadian Tuberculosis Standards, 6th Edition 2007, OHA Guidelines – Revised June 2008 and OHA/OMA Communicable Disease Surveillance Protocol #180)</i>
Hepatitis B Vaccination	Immunization dates and blood work (serology) are mandatory for the Paramedic Program. Hepatitis B proof of immunity (blood work) is MANDATORY prior to commencing any clinical experience. If you have not had the vaccine before, you should contact your healthcare provider to discuss receiving the accelerated/rapid dosage . <i>(Reference : OHA/OMA Communicable Disease Surveillance Protocol #206)</i>
Hepatitis A Vaccination	Hepatitis A is not mandatory but recommended. Hepatitis A (transmitted through fecal-oral route, blood borne) is a virus that infects the liver. <i>(Reference : OHA/OMA Communicable Disease Surveillance Protocol #206)</i>
Flu Shots	Flu shots are mandatory for the Paramedic program. If such immunizations are medically contraindicated, documentation must be provided. Individuals working with vulnerable populations have a duty to actively promote, implement and comply with influenza immunization recommendations. The flu vaccine is not available until October/November. Annual flu clinics are conducted on campus, date(s) to be announced. OR you can make arrangements with your physician, local Public Health Unit to have this completed. Be sure to retain a copy of this documentation to show to your placement agency. <i>(Reference : OHA/OMA Communicable Disease Surveillance Protocol #306)</i>
Communicable Disease Declaration	Completion of the Communicable Disease Declaration (Section D of the Health and Immunization Record) is required in compliance with the Ambulance Services Communicable Disease Standards . Some placement services may ask you to complete another declaration form signed by a physician.

It is advised that you get an appointment with your healthcare provider as soon as possible to ensure you are able to get the required documentation, vaccinations and blood tests (copies of blood results required) done in a timely fashion. Inquire at that time whether there will be a charge for this service.



HEALTH AND IMMUNIZATION RECORD FOR PARAMEDIC STUDENTS – 2010/11

Student to complete Sections A, B, C, D and E. Physician/Health Care Provider to complete Sections F, G, H and I.

A. STUDENT'S PERSONAL INFORMATION: (Please print)																																																		
Last Name: _____		Given Names: _____		Academic year 20_____																																														
Date of Birth: _____ Day/Month/Year		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>		Student Number: _____																																														
Complete Mailing Address: _____																																																		
Tel. Nos.: Home: _____ Work: (Optional) _____ Cell: _____ Alternate: _____			FOR OFFICE USE ONLY: Date Completed Form received _____ Day/Month/Year																																															
B. COMMUNICABLE DISEASE DECLARATION – TO BE COMPLETED BY THE STUDENT																																																		
<p>The declaration must be signed by the student in the presence of his/her healthcare provider. By signing below, (Section I) the student in the Paramedic program at Fanshawe College declares that, at this time, they are not under the care of a healthcare provider or being treated for any of the diseases listed in the table below (part of the Ambulance Service Communicable Disease Standards), and is thus in compliance with these requirements.</p>																																																		
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C. ALLERGIES AND MEDICATIONS – TO BE COMPLETED BY THE STUDENT																																																		
Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/>		Specify: Drugs/Vaccines	Latex	Foods	Other																																													
Sensitivities: Yes <input type="checkbox"/> No <input type="checkbox"/>																																																		
Medications: Are you currently taking any medications which may affect your ability to perform the duties? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please explain: _____																																																		
D. OTHER – TO BE COMPLETED BY THE STUDENT																																																		
Function																																																		
Walking	No Restrictions <input type="checkbox"/> Limit to _____ hrs/mins																																																	
	Comments: _____																																																	
Standing	No Restrictions <input type="checkbox"/> Limit to _____ hrs/mins																																																	
	Comments: _____																																																	

HEALTH AND IMMUNIZATION RECORD FOR PARAMEDIC STUDENTS – Page 2

Student Name: _____

Student Number: _____

SECTION D – OTHER (Cont'd) – TO BE COMPLETED BY THE STUDENT

Function

Sitting	No Restrictions <input type="checkbox"/> Limit to _____ hrs/mins Comments:
Bending/Twisting	No Restrictions <input type="checkbox"/> Limit to _____ hrs/mins Comments:
Pushing/Pulling	No Restrictions <input type="checkbox"/> Limit to _____ hrs/mins Comments:
Reaching	No Restrictions <input type="checkbox"/> Limit to _____ hrs/mins Comments:
Climbing	No Restrictions <input type="checkbox"/> Limit to _____ hrs/mins Comments:
Lifting	
• Floor to waist	No Restrictions <input type="checkbox"/> Limit to _____ Kgs. Comments:
• Waist to shoulder	No Restrictions <input type="checkbox"/> Limit to _____ Kgs. Comments:
• Above shoulder	No Restrictions <input type="checkbox"/> Limit to _____ Kgs. Comments:
Hearing	No Restrictions <input type="checkbox"/> Limitations _____ Comments

E. STUDENT'S SIGNATURE - MANDATORY

I have read and declare the information I have provided to be accurate to the best of my knowledge. My signature provides my consent to complete this evaluation as part of my pre-placement assessment. I understand that providing inaccurate or misleading information may lead to the termination of my placement privileges. Also, by signing this form I authorize the release of information concerning my status in regards to completion of current immunization and tuberculin skin testing to my faculty advisor or coordinator.

Student

Full Name: (Please print) _____

_____ Date

_____ (Signature – MANDATORY)

F. IMMUNIZATION RECORDS - TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER

Vaccination or Test	Date of Blood Work (required by Ambulance Standards)	Results of Blood Work (attach copy)	Dates of Immunizations (Day/month/year)
Chicken Pox (Varicella) antibodies Blood work required for proof of immunity	_____ (day/month/year)	Serology: Positive <input type="checkbox"/> Negative <input type="checkbox"/> → If negative, immunization required	#1 _____ (day/month/year) #2 _____ (day/month/year) Unless contraindicated
Measles, Mumps, Rubella (MMR) Blood work required for proof of immunity	_____ (day/month/year)	Serology: Positive <input type="checkbox"/> Negative <input type="checkbox"/> →	_____ (day/month/year)

HEALTH AND IMMUNIZATION RECORD FOR PARAMEDIC STUDENTS – Page 3

Student Name: _____

Student Number: _____

SECTION F – IMMUNIZATION RECORDS (Cont'd) – TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER

Hepatitis B antibodies Blood work required for proof of immunity	_____ (day/month/year)	Serology: Positive <input type="checkbox"/> Negative <input type="checkbox"/> →	Booster: #1 _____ #2 _____ #3 _____ (day/month/year)
Immunity required <input type="checkbox"/> Hepatitis B or <input type="checkbox"/> Twinrix May only require booster dose	1 st dose Date: _____ (day/month/year) Unless contraindicated	2 nd dose Date: _____ (day/month/year)	3 rd dose Date: _____ (day/month/year)
Repeat of Hepatitis B antibodies titre if required	_____ (day/month/year)	Serology: Positive <input type="checkbox"/> Negative <input type="checkbox"/> →	_____ (day/month/year)
Tetanus/Diphtheria/Pertussis/Polio Primary series – last dose (within last 10 years)	N/A	N/A	_____ (day/month/year)
Polio – (Ambulance Standards) (within last 10 years)	N/A	N/A	_____ (day/month/year)
Adacel → OR	N/A	N/A	_____ (day/month/year)
Tetanus/Diphtheria →	N/A	N/A	_____ (day/month/year)

G. TUBERCULOSIS – MANDATORY – TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER

TB Testing (Mantoux) _____ (day/month/year) Date Given: Step #1 _____	Date Read: _____	Results in mm: _____
Date Given: Step #2 (Mantoux) _____ (least one wk and no more than 4 wks after Step #1)	Date Read: _____	Results in mm: _____
Additional One-Step TB test (required if previous two-step dates are greater than one year) Date Given: _____	Date Read: _____	Results in mm: _____
IF MANTOUX TEST IS POSITIVE: CHEST X-RAY IS REQUIRED Date of X-Ray: _____	Results of X-Ray (attach copy): _____	

H. INFLUENZA (FLU) VACCINE – MANDATORY - TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER

MANDATORY for the Paramedic program. The flu vaccine is not available until October/November. Annual flu clinics are conducted on campus, date(s) to be announced. OR you can make arrangements with your physician/health care provider or local Public Health Unit. ***If such immunizations are medically contraindicated, documentation must be provided.***

Vaccination date(s): _____ , _____

HEALTH AND IMMUNIZATION RECORD FOR PARAMEDIC STUDENTS – Page 4

Student Name: _____

Student Number: _____

I. PHYSICIAN/HEALTH CARE PROVIDER'S INFORMATION AND SIGNATURE - MANDATORY

Physician/Health Care Provider

Full name: (Please print) _____

Address: _____

Telephone No(s): _____

I have performed a physical examination on this patient and find him/her to be healthy and free of communicable disease.

I have performed a physical examination on this patient and find he/she has the following medical problems:

Date

(Signature – MANDATORY)

STUDENTS MUST KEEP COPIES OF THIS FORM FOR THEIR PERSONAL RECORDS.

In accordance with section 39(2) of the Freedom of Information and Protection of Privacy Act, you are advised that the personal information collected on this form is collected under the authority of the "Ministry of Colleges and Universities Act", R.S.O., 1990 Regulation 770. Failure to provide current immunization documentation and proof of recent tuberculin skin testing as outlined for your program can affect your eligibility to attend the clinical or community placement components of your program.

FANSHAWE COLLEGE

