



#### **Student Instructions**

<b>Program Details</b>			
Program Name:	Practical Nursing	Code (#):1704X	Year:1
Requirements Due:	9/29/2023	_	

#### **Student Instructions for Mandatory Requirements**

1. Review the requirements checklist below

SECTION	REQUIREMENT	Ensure all requirements are complete with records and certificates included
	Tuberculosis Screening	
	Measles Mumps and Rubella (MMR)	
Continuo A DAndinol	Varicella (Chicken Pox)	
Section A – Medical	Tetanus/Diphtheria (Td)	
Requirements (Completed and signed	Pertussis	
by Health Care Provider)	Polio	
by riculti care rioviaciy	Hepatitis B	
	Influenza	
	COVID-19	
	CPR Level C Certificate	
Section B - Non-	Mask Fit Test Certificate	
Medical Requirements	Vulnerable Sector Police Check #1	
	Vulnerable Sector Police Check #2	

- 2. Access the **Algonquin College Placement Pass** website for the most current Pre-Placement Health Form Package: <u>Algonquincollege.placementpass.ca</u>
- 3. Book an appointment with a Physician or Nurse Practitioner
- 4. Bring vaccine records, public health forms or documents (including childhood records) that show your immunization history to your appointment.
- 5. Provide **Section A** (instructions and forms) to your health care provider to complete, and sign/stamp. **Note**: RNs/RPNs may also co-sign portions of the form.
- 6. Ensure your health care provider provides you with the following documents so you can submit these to Placement Pass with the health forms:
  - a. Vaccine records (for proof of immunization),
  - b. Lab blood results, and
  - c. Chest X-ray report, if required.
- 7. Complete Section B: Mandatory non-medical requirements
- 8. Complete checklist (above) to ensure all requirements are met for both sections (A & B):
  - a. Section A (both pages) completed, initialed, and signed by your Health Care Provider
  - b. Your blood lab reports and, if required, Chest X-Ray report
  - c. Your immunization vaccine records including childhood records if available. Ensure your **name** is on each record.
  - d. Section B certificates or proof of completion for any non-medical requirement
- 9. Scan, label, and submit all documents to the Placement Pass website located at:

Algonquincollege.placementpass.ca

- Students who started a vaccine series will receive a temporary exception after two doses Once available, they will submit vaccine records and/or blood test results confirming completion.
- Verify that documents are clear and legible before submitting to the Placement Pass website.
- ► Fees are charged for **each submission** except for flu and COVID records.



#### **Health Care Provider Instructions**

#### **Health Care Provider Instructions for Mandatory Medical Requirements**

- 1. Complete Section A in its entirety and provide an attesting signature/initial where indicated.
- 2. Provide the student a copy of vaccine records for vaccines administered and lab results for lab tests completed.

**Note**: Immunization requirements listed follow the standards outlined in: The Canadian Immunization Guide (Part 3) **Vaccination of Specific Populations** - Workers and Student Placements, The Canadian Tuberculosis Standards (2007), and the OHA/OMA Ontario Hospitals Communicable Disease Surveillance Protocols.

3. Use the following instructions when completing the following subsections:

#### a. Tuberculosis Screening:

- i. 2- step TB Mantoux skin test is required regardless of BCG history. TB tests should be given 1 to 3 weeks apart.
- ii. TB test is invalid if it is given in the 30-day period following the administration of any live vaccines. Ensure TB testing is complete before giving any live vaccines.
- iii. If a student was positive from a previous 2-step skin test, a TB test is not required; instead, proceed to a chest X-ray.
- iv. For any student who had completed a negative 2 step TB test, complete a 1-step only
- v. For any student who tests positive:
  - Include date and results from any previous positive TB skin testing
  - A chest X-ray is required (within 6 months of your program start, valid for 2 years)
  - Indicate any treatments that have been started.
  - Complete assessment and document on form if the student is clear of signs and symptoms of active TB. (This is an annual requirement)

#### b. Measles Mumps and Rubella (MMR):

- i. Either vaccine records of 2 doses of MMR vaccine is required or a lab blood test showing full immunity. If the lab blood test does not show full immunity and the student does not have any vaccine records of MMR, they will require 2 doses of MMR vaccine given 1 month apart.
- ii. An MMR booster is required if the student has a record of 1 dose of MMR vaccine. **Note:** This vaccine is not recommended (contraindicated) when pregnant. Pregnancy should be avoided for 3 months post immunization.

#### c. Varicella (Chicken Pox):

i. Either vaccine records of 2 doses of varicella vaccine or a lab blood test showing evidence of full immunity are required.

**Note:** This vaccine is not recommended (contraindicated) when pregnant. Pregnancy should be avoided for three months after a Varicella vaccination has been given.

#### d. Polio:

- i. Vaccine records showing an initial primary series are required.
- ii. If there are no records available, then give an adult primary series of 3 doses.



#### **Health Care Provider Instructions**

#### e. Tetanus/Diphtheria (Td) and Pertussis:

- i. Vaccine records showing an initial primary series are required.
- ii. If there are no records available, give adult primary series of 3 doses, dose #1 Tdap.
- iii. **Note:** National Advisory Commission on Immunization (NACI) as well as the OHA Surveillance Protocols recommends that all adults regardless of age should receive a single dose of tetanus diphtheria acellular pertussis (Tdap) for pertussis protection if not previously received in adulthood. The adult dose is in addition to the routine adolescent booster dose. The interval between the last tetanus diphtheria booster and the Tdap vaccine does not matter. **All students are required to provide proof of an adult dose of Tdap received on or after their 18th birthday.**

#### f. Hepatitis B:

- i. If previously immunized, a lab test must be obtained for evidence of immunity (antigen/antibody). Copies of lab results must be provided.
- ii. If the student has a completed initial primary series documented and serology results are < 10 IU/L, provide a booster dose. Another lab test 30 days following the booster is required to confirm immunity. **or** provide a second vaccine series.
- iii. If the student has not received the Hepatitis B vaccine 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 30 days following dose # 3.
- iv. If serology results are < 10 IU/L, dose # 4 is required, followed by another lab test 1 month after:
  - If serology results continue < 10 IU/L, continue with the vaccine series until competed, to be followed by another lab test 1 month after (\*may receive up to 6 doses).

#### g. Influenza (Flu)

- i. Only applicable during flu season (October to the end of April)
- ii. Influenza vaccine is strongly recommended for the indicated program.
- iii. If a medical exemption to flu vaccination is indicated, the document must follow current NACI recommendations.

**Note:** Student must sign the influenza waiver if they do not intend to get the seasonal flu shot (see page 2, Section A).

#### h. COVID-19

- i. Proof of vaccination is required for each dose (including booster) of COVID-19 vaccine, or
- ii. If a medical exemption to COVID-19 vaccination is indicated, a medical note is required which follows the process as outlined in the current NACI guidelines for a physician requested medical exemption of COVID-19 immunization. It must include:
  - the medical reason they cannot be vaccinated for COVID-19, and
  - the effective time period for the medical reason (i.e., permanent, or time-limited).

**Note:** Student must sign the COVID-19 waiver if they do not intend to get some or any of the COVID-19 immunization doses. (See page 2, Section A)

- 4. Complete Health Care Provider Signature and Identification subsection.
  - i. To be completed by each health care provider who has provided information in Section A (to match initials on the form to signature)



## **SECTION A: Health Care Provider Form**

	leave any sections blank – If no t with a copy of the lab report/r		•				•
Student Name:				Studer	nt ID:		
TUBERCULOSIS SCR Initial 2-Step Manto	EENING oux Test – mandatory	Date Administe	aren I		ad (48-72 m testing)	(Ind	Results * luration in mm)
1-step	step		D	YYYY/N	1M/DD m		mm
2-step (7-28 days af	ter one-step)	YYYY/MM/D	YYYY/MM/DD YYYY/MM/DD		mm		
completed previous	2-step TB skin test has been ly with negative results; rious 2- step in space above)	YYYY/MM/D	D	YYYY/MM/DD		mm	
*10 mm or more:	$\square$ Positive $\square$ Negative	ve □ N/A Date of Chest X-Ray: YYYY/MM/DE			YYY/MM/DD		
Signs/symptoms of a	ctive TB on physical exam?	□ Yes □ N	o		Health Care	e Prov	ider Initials:
MEASLES MUMPS A	AND RUBELLA (MMR)	Dos	se 1			Dos	se <b>2</b>
Date Vaccine Admin	istered:	YYYY/MM/DD YYY		YYY/N	1M/DD		
Immune to MMR?	☐ Yes ☐ No				Health Care	e Prov	ider Initials:
VARICELLA (CHICKE	N POX)	Dose 1		Dose 2			
Date Vaccine Admin	istered:	YYYY/MM/DD		YYYY/MM/DD			
Immune to Varicella?	yes □ No				Health Care	e Prov	ider Initials:
POLIO		Dose 1		Dos	e 2		Dose 3
Date Vaccine Admin	istered:	YYYY/MM/DD YYY		YYYY/IV	/MM/DD YYYY/MM/D		YYY/MM/DD
Initial primary series	completed? ☐ Yes ☐ No	If no, provide pr	imary se	ries 3 do	ses	Н	CP Initials:
TETANUS/DIPHTHE	RIA (TD) AND PERTUSSIS	Tdap booster Do		Dos	se 2 Dose 3		Dose 3
Date Vaccine Admin	istered:	YYYY/MM/DD YYYY/N		MM/DD YYYY/MM/DD			
Initial primary series	completed? □ Yes □ No	If no, provide pr	imary se	ries 3 do	ses	Н	CP Initials:
HEPATITIS B		Dose 1	Dos	se 2	Dose 3	3	Booster
	Date Vaccine Administered:	YYYY/MM/DD	YYYY/N	/IM/DD	YYYY/MM	/DD	YYYY/MM/DD
Initial Series	Product Name:						
Second Series	Date Vaccine Administered:	YYYY/MM/DD	YYYY/N	/M/DD			
	Product Name:						
Immune to Hepatitis Do lab test results one	B?	e "immune Hepati	tis B"? □	] Yes□ N	lo□ N/A	Н	CP Initials:



## **SECTION A: Health Care Provider Form**

Student Name: Student ID:			nt ID:		
INFLUENZA (FLU)		Seasonal Dose			
Date Vaccine Administered:		YYYY/MM/DD			
Product Name:					
	Provide vaccine record or Hea	lth Car	e Provider signature:		
Influenza Waiver: Students who choose not to have the annual influenza vaccine for medical or personal reasons must sign to acknowledge their awareness of susceptibility to the disease and of the implications for clinical placement and lost time.		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.  Student Signature:			
COVID-19			Dose 1	Dose 2	
Full Series	Date Vaccine Administered:		YYYY/MM/DD	YYYY/MM/DD	
Provide vaccine record	Product Name:				
Booster Dose(s)	Date Vaccine Administered:	YYYY/MM/DD		YYYY/MM/DD	
Provide vaccine record	Product Name:				
<b>COVID-19 Waiver</b> : Booster doses are strongly recommended as these requirements are based on the placement organizations and their policies and subject to change.		By signing this waiver, I understand that if I fail to submit proof of vaccination for COVID-19 or medical documentation outlining why I am unable to receive the COVID-19 vaccine, I may be unable to attend clinical placement due to placement agency requirements, thereby jeopardizing successful completion of the program.  Student Signature:			
Health Care Provid	er Signature & Identification				
	•		Professiona	al Identification Stamp:	
Printed Name: Signature: Initials: Designation: Phone Number:	□ MD □ RN (EC) □ RN/RPN □ ( ) -	]PA			
Health Care Provide	er Signature & Identification				
			Professiona	al Identification Stamp:	
Printed Name:					
Signature:					
Initials: Designation:					
Phone Number: ( ) -					
·					



# **SECTION B: Mandatory Non-Medical Requirements**

Student	Details					
Student	Name:	Student ID (#):				
Program	n Name:	Code (#): Year:				
Yearly R	equirements to remain valid until:					
-		☐ Winter Start ( <b>September 1</b> )	☐ Spring Start ( <b>December 15</b> )			
	` ,					
	Review your communication including date to apply and a	from your program to find out wh ny other special instructions.	en to obtain these requirements			
	► Ensure annual requirements <b>remain valid</b> until completion of your academic year (see dates above).					
•	Submit supporting documents in PDF format, if possible.					
	▶ Verify that documents are clear and legible before submitting to the Placement Pass website.					
NON-M	EDICAL REQUIREMENTS					

NON-MEDICAL REQUIREMENTS			
CPR C Certificate (valid for 1 year)			
N95 Mask Fit Test Certificate (va	lid for 2 years)		
Fall competer start	Vulnerable Sector Police Check #1 (valid 6 months) Must be dated after July 1st – due September 15th.		
Fall semester start	Vulnerable Sector Police Check #2 (valid 6 months) Must be dated after December 1st – due March 1st		
Winter semester start	Vulnerable Sector Police Check #1 (valid 6 months) Must be dated after November 1st – due January 15th		
willer semester start	Vulnerable Sector Police Check #2 (valid 6 months) must be dated after March 1st – due May 1		
Spring competer start	Vulnerable Sector Police Check #1 (valid 6 months) Must be dated after February 1st.		
Spring semester start	Vulnerable Sector Police Check #2 (valid 6 months) must be dated after July 1st.		