Clinical/Field Pre-Placement Health Form

Program Name: Peri-Operative RN

Program Code (#): 0664X
Program Year: Year 1

Student Information
Last Name: **First Name**: **Student I.D. Number**:
Email: **Home Phone**: **Cell Phone**:
Residential Address:

Bring to Your Health Care Provider Appointment

1. This form.
2. Yellow immunization card and/or regional health unit forms that denote record of your immunization history.
3. Other proof of immunization such as blood tests and/or lab results.

Hint: From your local public health unit in the area that you lived when you received high school and elementary school immunizations.

Important - Please make sure this form is completed in all of the following sections:

Section A: Mandatory Medical Requirements: to be completed by your health care provider (Physician, Nurse Practitioner or Registered Nurse)

Ask your health care provider to:

- Complete all of Section A.
- Complete all shaded areas.
- Provide you with proof of immunization and/or lab blood results for identified sections.
- Sign and date at the end of the section.

Section B: Other Medical Requirements: Must be completed by you, the student.
Section C: Mandatory Non-Medical Requirements: Must be completed by you, the student.
Section D: Student Agreement: Must be completed by you, the student.
Section E: Completed by the Requisite Program Nurse.

Complete the checklist on the last page to make sure you have everything
before you make your appointment with the Requisite Nurse at https://algonquin.requisite.ca.

Section A: Medical Requirements – Mandatory

Instructions for Physician/Nurse Practitioner/ Registered Nurse: Please read carefully.
Thank you for your cooperation with the immunization process for our student registered in this program. For the protection of students, patients and external clients, students must provide documented proof of immunization. Immunization requirements listed before each section follow the standards outlined in the Canadian Immunization Guide, Evergreen Edition, Part 4, Active Vaccines (2012), the Canadian Tuberculosis Standards (2007) and the OHA/OMA Ontario Hospitals Communicable Disease Surveillance Protocols. The required information with exact dates (yy/mm/dd) and signature for each requirement must be recorded directly on this Clinical Pre-placement Health Form in the shaded areas provided. Please also provide an attesting signature at the end of the form. Failure to complete in its entirety and submit this form by the required deadline, will exclude student from their clinical/field placement.

Please ensure you have reviewed, completed and signed the required shaded areas in Section A.

Measles Mumps and Rubella (MMR)

Instructions:
The Student must provide proof that they have received two doses of the MMR vaccine. In the absence of documented proof of two full doses, a lab blood test must be obtained for evidence of immunity.

If the student has a negative, non-reactive, or indeterminate MMR titre lab test result and has no documented proof of previously receiving MMR vaccine, they will require 2 doses of MMR vaccine given one month apart.

If the student has evidence of previously only receiving one full dose of MMR vaccine they are to receive one booster dose.

Copies of lab results must be provided for all three of the lab results. This vaccine is not recommended (contraindicated) for pregnant women and pregnancy should be avoided for 3 months post immunization

Previous MMR Doses:

- MMR Vaccine Given (Dose 1): Date:_____
- MMR Vaccine Given (Dose 2): Date:_____

If required
Lab Report/Results (Attach laboratory blood report for each)

Immunity	Yes	No	
Measles	❑	❑	
Mumps	❑	❑	
Rubella	❑	❑	

For Requisite Nurse Only	Yes	No
Lab results provided	❑	❑
Lab results provided	❑	❑
Lab results provided	❑	❑

To be given If required
MMR Dose #1: Date:_____
MMR Dose #2: Date:_____
Note: If MMR Vaccine is given, must provide proof of immunization and/or immunization health record is required.

Health Care Provider Initials:_____ Date:_____

For Requisite Nurse Only	Yes	No
Cleared	❑	❑
Exception	❑	❑

Requisite

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Tuberculosis Screening

Instructions:

1. All students must have documented proof of a Two-Step TB Mantoux skin test. If proof is not available for the Two-Step Mantoux skin test or if it has not been completed previously, then the student must receive an initial Two-Step TB Mantoux skin test. The Two-Step needs to be performed **ONCE** only and it never needs to be repeated again. Any subsequent TB skin tests can be One-Step, regardless of how long it has been since the last skin test. Students who have received a BCG vaccination are **not exempt** from the initial Mantoux testing. Pregnancy is **NOT** a contraindication for performance of a Mantoux skin test.
2. Mantoux testing must be completed prior to the administration of any live vaccines (i.e. MMR, IPV) **OR** defer skin testing for 30 days after the vaccine is given.
3. If a student was **positive** from a previous Mantoux Two-Step skin test and/or has received TB treatment, the health care provider must complete an assessment and document below if student is free from signs and symptoms of active tuberculosis.
4. Any student who has proof of a previous **negative** Two-Step, must complete a One-Step.
5. For any student who tests positive for the first time:
   a. Include results from the positive Mantoux screening (mm of induration).
   b. A chest x-ray is required and the report must be enclosed in this package.
   c. Indicate any treatments that have been started.
   d. Complete assessment and document on form if the student is clear of signs and symptoms of active TB.
   e. The responsibility for follow up lies with the health care provider as per the OHA/OMA Communicable Disease Surveillance Protocols.

Results

Initial Two-Step Mantoux Test – Mandatory	**Date Given**	**Date Read** (48-72 hours from testing)	**Results** (Induration in mm)
One-Step			
Two-Step (7-28 days after one-step)			
Annual One-Step (If the initial Two-Step TB skin test has been completed with negative results, complete one-step only)			

Note: Must provide proof of Mantoux One-Step, Two-Step TB skin test results.

If either step is positive (10 mm or more), please evaluate the following:

1. Chest x-ray results: ❑ Positive ❑ Negative ❑ N/A Date:_____
2. Does this student have signs and symptoms of active TB on physical exam? ❑ Yes ❑ No

Health Care Provider Initials:_____ Date:_____

For Requisite Nurse Only	**Yes**	**No**
Chest x-ray provided	❑	❑
Cleared	❑	❑
Exception	❑	❑

Varicella (Chicken Pox)

Instructions:
Either a lab blood test must be obtained for evidence of immunity or documented proof of a full 2 dose varicella series. Copies of lab blood results must be provided. The Varicella vaccine is required if lab reports show no immunity. This vaccine is not recommended (contraindicated) for pregnant women. Pregnancy should be avoided for three months after a Varicella vaccination has been given.

Mandatory Lab Report/Results (Attach laboratory blood report)
Immune to varicella? ❑ Yes ❑ No

If blood results non reactive provide student with varicella vaccine:

- Varicella Vaccine Given (Dose 1): Date:_____
- Varicella Vaccine Given (Dose 2): Date:_____

If blood results indeterminate provide student with varicella vaccine:

- Varicella Vaccine Given (Dose 1): Date:_____
- Serology 3 months post vaccination: Immune to varicella? ❑ Yes ❑ No

Must provide proof of varicella immunization and/or attach immunization health record.

Health Care Provider Initials:_____ Date:_____

For Requisite Nurse Only	Yes	No
Lab results provided	❑	❑
Cleared	❑	❑
Exception	❑	❑

Tetanus/Diphtheria (Td)

Instructions

1) Initial primary series completed with booster if more than 10 years.
2) If no proof of initial primary series in childhood or adulthood give 3 doses.

Immunization	Yes	No	Date
Initial primary series completed	❑	❑	
Booster completed	❑	❑	
Booster given (if required)	❑	❑	

If primary adult series required:

- Tetanus/Diphtheria (Td) Given (Dose 1): Date:_____
- Tetanus/Diphtheria (Td) Given (Dose 2): Date:_____
- Tetanus/Diphtheria (Td) Given (Dose 3): Date:_____

Must provide proof of tetanus/diphtheria immunization and/or attach immunization health record.

Health Care Provider Initials:_____ Date:_____

For Requisite Nurse Only	Yes	No
Cleared	❑	❑
Exception	❑	❑

Pertussis

Instructions:
The OHA Pertussis Surveillance Protocol for Ontario Hospitals states that all adult HCW's (including students) regardless of age should receive a single dose of tetanus diphtheria accellular 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 to provide proof of an adult dose of Tdap received on or after their 18th birthday.

Adult dose of Tdap complete? ❑ Yes ❑ No

- If yes, provide date:_____
- If no:
  - Adacel or equivalent given: Date:_____

Health Care Provider Initials:_____ Date:_____

For Requisite Nurse Only	Yes	No
Cleared	❑	❑
Exception	❑	❑

Polio

Instructions:
Date and proof of completed initial primary series. If student has never been immunized or there is no documented proof, then give adult primary series of 3 doses.

Initial primary series completed? ❑ Yes ❑ No

- **If no, give adult primary series:**
  - Polio Given (Dose 1): Date:_____
  - Polio Given (Dose 2) at 4 to 8 weeks: Date:_____
  - Polio Given (Dose 3) at 6 to 12 months: Date:_____

Must provide proof of polio immunization and/or attach immunization health record.

Health Care Provider Initials:_____ Date:_____

For Requisite Nurse Only	Yes	No
Cleared	❑	❑
Exception		

Requisite

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Hepatitis B

Instructions

1) A lab blood test must be obtained for evidence of immunity (antigen/antibody). **Copies of lab results must be provided.**
2) If the student has documentation of a completed initial primary series and serology results are < 10 IU/L, provide a booster dose and complete another lab test 30 days following the booster. Students must provide documented proof that they have received the initial primary series for Hepatitis B vaccine. **OR**

1) If the student has not received the Hepatitis B vaccine and serology results are < 10 IU/L 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.**

If blood work results are negative, student will need a Dose # 4 followed by another lab test one month after.
If still negative, have dose # 5 & 6 followed by another lab test (Can only have up to 6 doses).

Mandatory Lap Report/Results

a) Immune, Hepatitis B: ❑ Yes ❑ No

- If not immune and initial primary series **completed**, provide booster. Date:_____

b) Lab test results, one month post booster: Immune, Hepatitis B: ❑ Yes ❑ No

- If not immune and initial primary series **not completed**, provide initial primary series for hepatitis B as:
  - Hepatitis B Vaccine Given (Dose 1). Date:_____
  - Hepatitis B Vaccine Given (Dose 2). Date:_____
  - Hepatitis B Vaccine Given (Dose 3). Date:_____

c) Lab test results, post initial primary series: Immune, Hepatitis B: ❑ Yes ❑ No Actual Result:_____

- If not immune after initial primary series, provide additional doses:
  - Hepatitis B Vaccine Given (Dose 4). Date:_____

d) Lab test results, one-month post dose 4: Immune, Hepatitis B: ❑ Yes ❑ No Actual Result:_____

- If not immune after additional doses, provide 5 and 6th dose:
  - Hepatitis B Vaccine Given (Dose 5). Date:_____
  - Hepatitis B Vaccine Given (Dose 6). Date:_____

e) Lab test results, one-month post dose 6: Immune, Hepatitis B: ❑ Yes ❑ No Actual Result:_____

Health Care Provider Initials:_____ Date:_____

For Requisite Nurse Only	Yes	No	N/A
Level **a)** lab results provided	❑	❑	
Level **b)** lab results provided	❑	❑	❑
Cleared	❑	❑	
Exception	❑	❑	

To be completed by the health care provider.
Please complete the shaded area below OR provide professional identification stamp.

Signature: _____

Designation (circle one): **MD** **RN(EC)** **RN**

Initials: _____

Print Name: _____

Phone Number: _____

Stamp Area

Signature: _____

Designation (circle one): **MD** **RN(EC)** **RN**

Initials: _____

Print Name: _____

Phone Number: _____

Stamp Area

Section B: Other Medical Requirements

Influenza: Mandatory

Instructions:
Influenza Vaccination (Flu Shot): Flu vaccine is usually available from October to March or April every year. All students are required to receive an annual seasonal influenza immunization during flu season and this must be completed at ***least 10 days prior to the start of their clinical placement***. Proof of flu vaccination must be submitted to ParaMed in order for the date of the student's flu shot to be updated to the Requisite system.

If a student has documentation indicating a medical exemption to the influenza vaccine it must follow current NACI recommendations.

Students who have not received their flu vaccination during the flu season *will be removed* from clinical placement thereby jeopardizing successful completion of the clinical course. Placement partners require that students receive influenza immunization *and show proof* especially if there is an outbreak.

Proof of flu vaccine can be emailed to ParaMed at: WWW.algonquin.requisite@paramed.com

Results:
Seasonal flu vaccine received on date:_____
Other vaccine received:_____

For Requisite Nurse Only	Yes	No
Document provided	❑	❑
Cleared	❑	❑
Exception	❑	❑

Section C: Mandatory Non-Medical Requirements

Instructions for Students:

As a student accepted in this program, you are required to complete the following non-medical requirements.

1) Review your communication package to find out how and where to obtain these requirements.
2) Locate the approved sources to obtain the requirement(s).
3) Obtain the certificate/proof of completion.
4) If pregnant and plan to obtain Mask Fit test from ParaMed, must have medical clearance (a note) from health care practitioner.
5) For each of the non-medical requirement(s), bring the original and one copy of your certificate and/or proof of completion to your Requisite appointment.
6) Complete the shaded columns only. The last two columns are for Requisite Nurse Use Only.

If you have previously obtained one or more of the above non-medical requirements, please ensure they have not expired (if applicable).

Non-Medical Requirements	Date Issued	Expiry Date	Document Provided	Cleared
CPR Level C Certificate Card (annual recertification)			❑	❑
Mask Fit Testing (completed every two years)			❑	❑
Vulnerable Sector Police Check (annual)			❑	❑

Section D: Student Health Form Agreement

Section D - The Student Health Form 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 ParaMed Requisite Program 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.

Signature: _____ **Date:** _____

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.

Section E: To be completed by Requisite Nurse

Initial Visit

Pre-placement Requirement Status	Yes	No	Date	Stamp – ParaMed Requisite Office Use Only
Cleared	❑	❑		
Exception	❑	❑		
Agreement Form	❑	❑		

Nurse Signature: _____

Nurse Name (Print): _____

Date: _____

Data entered into Requisite Software by: _____

Date: _____

Subsequent Visit

Pre-placement Requirement Status	Yes	No	Date	Stamp – ParaMed Requisite Office Use Only
Cleared	❑	❑		
Exception	❑	❑		
Agreement Form	❑	❑		

Nurse Signature: _____

Nurse Name (Print): _____

Date: _____

Data entered into Requisite Software by: _____

Date: _____

Is My Clinical/Field Pre-placement Health Form Completed? – Checklist

Bring to your Requisite appointment:

- This form.
- Your blood lab reports – as required.
- Your yellow immunization card or other proof of immunization (Hint: obtain from your local public health unit in the area that you lived when you received high school and elementary school immunizations.)
- A photocopy of all documents.

Section A– Mandatory Medical Requirements	**Was Section A completed by the health care provider?**	**Was it signed by health care provider?**	**Do I have all the required documents attached?** (proof of immunization/blood lab report)
Measles Mumps and Rubella (MMR)	❑	❑	❑
Tuberculosis Screening	❑	❑	❑
Varicella (Chicken Pox)	❑	❑	❑
Tetanus/Diphtheria (Td)	❑	❑	❑
Pertussis	❑	❑	❑
Polio	❑	❑	❑
Hepatitis B	❑	❑	❑

Section B – Other Medical Requirements	**Did I complete all sections**	**Are the required documents attached**
Influenza Immunization	❑	❑

Section C – Mandatory Non-Medical Requirements	Did I complete?	Do I have the required documents attached (certificates)?
CPR Level C Certificate Card (annual recertification)	❑	❑
Mask Fit Testing (completed every two years)	❑	❑
Vulnerable Sector Police Check (annual)	❑	❑

Section D – Student Health Form Agreement	Did I read, sign, and date
Student Health Form Agreement	❑