

## Clinical/Field Pre-Placement Health Form

**Program Name:** Social Service Worker **Program Code (#):** 0432X **Program Year:**  
Year 1 Fall 2022 **Program Descriptor:** Full Time

### Student Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Student  
email: \_\_\_\_\_

### Bring to Your Health Care Provider Appointment and Submit to Placement Pass:

1. This form which your Health Care Provider will need to sign.
2. Any immunization cards, regional health unit forms or documents that show record of your immunization history. 3. Other evidence of immunity such as previous blood test results or previous TB skin test results.

**Important - Please make sure this form is completed in all sections:**

**Section A: Mandatory Medical Requirements:** to be completed by your health care provider (Physician, Nurse Practitioner, or Physician Assistant) RNs/ RPNs may also co-sign portions of the form

**Ask your health care provider to:**

- Complete all the shaded areas in Section A, initial each page and complete the Health Care Provider Identification page
- Provide you with proof of immunization, lab blood results and/ or Chest X-Ray report (if required) for identified sections.
- **Medical requirements due by October 15<sup>th</sup>, 2022**

**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.

**Complete the checklist on the last page to make sure you have everything before you scan and submit your documents to Placement Pass at <https://algonquincollege.placementpass.ca/>**

## Section A: Medical Requirements – Mandatory

**Instructions for the Health Care Providers: 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- Part 3- Vaccination of Specific Populations, the Canadian Tuberculosis Standards (2007) and the OHA/OMA Ontario Hospitals Communicable Disease Surveillance Protocols. The required information with exact dates (yyyy/mm/dd) and signature for each requirement must be recorded directly on this Clinical Preplacement Health Form in the shaded areas provided. Please also provide an attesting signature at the end of the Section A. Failure to complete in its entirety and submit this form by the required deadline, will exclude student from their clinical/field placement.

**Please Note:**

Update published September 28, 2021

NACI recommends that COVID-19 vaccines may be given concomitantly with, or at any time before or after, other vaccines including live, non-live, adjuvanted, or unadjuvanted vaccines. Since COVID-19 vaccine programs were first implemented, evidence on the efficacy/effectiveness, immunogenicity, and safety of COVID-19 vaccines currently authorized in Canada has been accumulating. Combined with the extensive data and experience on the concomitant administration of non-COVID-19 vaccines for routine immunizations, NACI has concluded that a precautionary approach is now no longer necessary and recommends that COVID-19 vaccines may be given concomitantly with (i.e. same day), or any time before, non-COVID19 vaccines (including live, non-live, adjuvanted, or unadjuvanted).

**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. If no records are available, a lab blood test must be obtained for evidence of immunity. MMR booster is required if there is a negative, non-reactive, or indeterminate MMR titre lab test result. **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 drawn provide Lab Report/Results (Attach laboratory blood report)**

Immune to MMR?  Yes  No

**If Booster Required**

- MMR Booster Given: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** Please provide a separate immunization record for any vaccines administered

**Health Care Provider Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Tuberculosis Screening**

**Instructions:**

1. A 2- Step TB Mantoux skin test is required regardless of BCG history. The TB tests should be given 1 to 3 weeks apart.
2. A TB test is invalid if it is given in the 30 day period following the administration of any live vaccines (i.e. MMR) Please ensure TB testing is complete before giving any live vaccines.
3. If a student was **positive** from a previous 2-Step skin test (induration measuring equal to or greater than 10mm) a TB test is not required. Proceed instead to a Chest X-Ray.
4. For any student who tests positive:
  - a. Include results from the positive TB skin test if available
  - b. A chest x-ray is required (within 6 months of your program start, valid for 2 years)
  - 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. (This is an **annual** requirement)

**Results**

<b>Initial Two-Step Mantoux Test – Mandatory</b>	<b>Date Given</b>	<b>Date Read (4872 hours from testing)</b>	<b>Results (Induration in mm)</b>
One-Step			
Two-Step (7-28 days after one-step)			
<b>Annual One-Step</b> (If an initial Two-Step TB skin test has been completed with negative results, complete one-step only)- <i>please provide proof of a previous 2 Step TB Skin Test</i>			

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

1. Chest x-ray results: Positive: \_\_\_\_\_ Negative: \_\_\_\_\_ N/A: \_\_\_\_\_  
Date of Chest X-Ray: \_\_\_\_\_

2. Does this student have signs and symptoms of active TB on physical exam?  
Yes: \_\_\_\_ No: \_\_\_\_

**Health Care Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Varicella (Chicken Pox)

### Instructions:

Either evidence of 2 lifetime doses of varicella vaccine is required or a lab blood test showing evidence of full immunity. Please provide copies of lab blood results. This vaccine is not recommended (contraindicated) for pregnant women. Pregnancy should be avoided for three months after a Varicella vaccination has been given.

### Previous Varicella vaccine doses:

- Varicella Vaccine Given (Dose 1): Date: \_\_\_\_\_
- Varicella Vaccine Given (Dose 2): Date: \_\_\_\_\_

### **If drawn provide Lab Report/Results (Attach laboratory blood report)**

Immune to varicella?  Yes  No

### **If blood results nonreactive 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: \_\_\_\_\_

**Note:** Please provide a separate immunization record for any vaccines administered

**Health Care Provider Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Polio

### Instructions:

Date and proof of completed initial primary series. If student has never been immunized or there are no records available, 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: \_\_\_\_\_

**Note:** Please provide a separate immunization record for any vaccines administered

**Health Care Provider Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## 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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Booster completed	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Booster given (if required)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

**If student does not have immunization records of previous doses- primary adult series required:**

- Tetanus/Diphtheria/Pertussis (Tdap) Given (Dose 1): Date: \_\_\_\_\_
- Tetanus/Diphtheria (Td) Given (Dose 2): Date: \_\_\_\_\_
- Tetanus/Diphtheria (Td) Given (Dose 3): Date: \_\_\_\_\_

**Note:** Please provide a separate immunization record for any vaccines administered

**Health Care Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## 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 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 18<sup>th</sup> birthday.**

**Adult dose of Tdap complete?**  Yes  No • If

yes, provide date: \_\_\_\_\_ • If

no:

○ Adacel or equivalent given: Date: \_\_\_\_\_

**Health Care Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## 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 junior or adult 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 of Hepatitis B vaccine.
- 3) If the student has never received the Hepatitis B vaccine provide the 3 dose adult 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.**

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

**Mandatory Lab Report/Results**

- a) **Immune**, Hepatitis B:  Yes  No
  - o If not immune and initial series completed, provide Hepatitis B Vaccine Booster Date: \_\_\_\_\_
  - o Lab test results, one month post booster: **Immune**, Hepatitis B:  Yes  No
- b) If **not immune** and initial series **not completed**, provide the 3 dose adult series for hepatitis B:
  - o Hepatitis B Vaccine (Dose 1). Date: \_\_\_\_\_ o Hepatitis B Vaccine (Dose 2). Date: \_\_\_\_\_ o Hepatitis B Vaccine (Dose 3). Date: \_\_\_\_\_
  - o Lab test results, post initial primary series: **Immune**, Hepatitis B:  Yes  No
- c) If **not immune** after the 3 dose adult series, provide additional doses:
  - o Hepatitis B Vaccine (Dose 4). Date: \_\_\_\_\_
  - o Lab test results, one-month post dose 4: **Immune**, Hepatitis B:  Yes  No
- d) If **not immune** after additional dose, provide doses 5 and 6:
  - o Hepatitis B Vaccine (Dose 5). Date: \_\_\_\_\_ o Hepatitis B Vaccine (Dose 6). Date: \_\_\_\_\_
  - o Lab test results, one-month post dose 6: **Immune**, Hepatitis B:  Yes  No

**Note:** Please provide a separate immunization record for any vaccines administered

**Health Care Provider Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Health Care Provider Signature and Identification**

To be completed by any the health care provider who has provided information on this form (to match initials on the form to signature) Please complete the area below OR provide professional identification stamp.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Designation (circle) MD    RN(EC)    RN/RPN    PA

Initials: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Designation

(circle) MD    RN(EC)    RN/RPN    PA

Initials: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Section B: Other Medical Requirements

### COVID-19 Vaccine: Mandatory

**Instructions:**

The Government of Ontario has issued a directive mandating hospitals and home and community care service providers to have a COVID-19 vaccination policy for employees, learners, and volunteers in all settings. Such policy must require these individuals to provide one of the following: **proof of full vaccination against COVID-19** or **written proof of a medical reason for not being vaccinated against COVID-19**. Proof of completion of a COVID-19 vaccination educational session may also be required.

Learners/Students not vaccinated must submit to regular point of care testing for COVID-19 and demonstrate a negative result, at intervals to be determined by the placement facility. (i.e. may need to be completed within the 48hrs prior to entering the placement facility for the duration of the placement). **Arrangements and costs for these tests will be the sole responsibility of the learner/student.**

Effective September 7th, 2021- **Prior to attending clinical placements, learners/students are required to:**



- Ensure they meet the COVID vaccination placement eligibility criteria, as defined by the placement site.
- Submit COVID vaccine records of proof of full COVID-19 vaccination **OR**
- For learners/students who are not vaccinated, they must submit medical documentation completed by their Health Care Provider that outlines their reasoning for a medical exemption request.
- If the student is not vaccinated, the college will contact the placement facility to determine eligibility for exemption on a case-by-case basis.

**Prior to attending clinical placement, students are required to submit their proof of vaccination to <https://algonquincollege.placementpass.ca/> and have the document available to provide to the placement facility.**

**Please note: As recommended by the National Advisory Commission on Immunization (NACI) in an update published 28 September 2021, COVID-19 vaccines may be given at the same as, or any time before or after, other vaccines, including live, non-live, adjuvanted or unadjuvanted vaccines**

**Your COVID-19 vaccines can be submitted anytime to <https://algonquincollege.placementpass.ca/> without an additional fee.**

**Results:**

**Dose #1:** Date of COVID-19 vaccine: \_\_\_\_\_

Type of COVID-19 vaccine: \_\_\_\_\_

**Dose #2:** Date of COVID-19 vaccine: \_\_\_\_\_

Type of COVID-19 vaccine: \_\_\_\_\_

(If required as part of a 2 dose series COVID-19 vaccine)

**Booster Dose (as required by the local public health department):** Date \_\_\_\_\_  
of COVID-19 vaccine: \_\_\_\_\_  
Type of COVID-19 vaccine: \_\_\_\_\_

**For Learner/Student to Sign only when they choose to NOT receive the COVID-19 vaccine:**  
**COVID-19 Vaccination Waiver**

Students who choose not to have the COVID-19 vaccine for personal reasons must sign below to acknowledge their awareness of susceptibility to the disease and of the implications for clinical placement and lost time. Those who have chosen not to be inoculated with COVID-19 vaccine will be required to provide proof of a negative COVID test completed within 48 hours of entering the placement facility.

- I understand that it is a mandatory requirement that students complete a full COVID-19 vaccination series for placement eligibility.
- I have selected to waive this immunization based on personal reasons.
- I am aware that I **may be susceptible** to COVID-19.
- I understand that I **may not be** eligible to attend clinical placement and therefore this may impede my progression through the program of study.
- I consent to have my program communicate my COVID-19 vaccination status to clinical placement agencies.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**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 from your program to find out when to obtain these requirements including date to apply and any other special instructions.
- 2) Locate the approved sources to obtain the requirement(s).
- 3) Obtain the certificate/proof of completion.
- 4) Student is to complete the Date of Issue and Expiry Date. Refer to your communications from your program which will have the details regarding the earliest date to apply and when these certificates must remain valid until.

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

Non-Medical Requirements	Date Issued	Expiry Date
Standard First Aid and CPR Level C Certification- Due by October 15 <sup>th</sup> , 2022 (not to expire before April 30 <sup>th</sup> , 2023)		
Workplace Hazardous Materials Information System (WHMIS) Certification- Due by October 15 <sup>th</sup> , 2022		

Ontario Worker Health and Safety Awareness (OWHSA) Certification- Due by October 15 <sup>th</sup> , 2022		
Authorization to Release HealthCare and Police Information Form- Due by September 16 <sup>th</sup> , 2022		

## 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 the applicable Provincial Public Health and Hospital Communicable Disease Surveillance Protocols, 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 not be able to view the results from this form, save for any nurse determinations made by ParaMed, the expiry dates thereof and whether any requirements related to the placement contemplated hereunder have been met.

I understand that I must have all sections of this form fully completed and reviewed by Placement Pass 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. Students are encouraged to review the privacy policy and terms of use of ParaMed, which can be found at: <https://www.paramed.com/privacy/>*

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

**Remember to scan, label, and submit the following documents- you can download a free mobile scanning APP to your phone to scan and upload**

- The full Pre-Placement Health Form initialed and signed by your Health Care Provider
- Your blood lab reports
- If required, Chest X-Ray report
- Your yellow immunization card/ booklet or other immunization records such as public health documents, provincial health board records, medical centre/ physician office letters or print outs, pharmacist’s immunization record or form
- Certificate or proof of completion for any non-medical requirements

<b>Section A– Mandatory Medical Requirements</b>	<b>Was Section A completed by the health care provider?</b>	<b>Was it signed by health care provider?</b>	<b>Are all the required documents attached? (proof of immunization/blood lab report)</b>
Measles Mumps and Rubella (MMR)	→	→	→
Tuberculosis Screening	→	→	→
Varicella (Chicken Pox)	→	→	→
Tetanus/Diphtheria (Td)	→	→	→
Pertussis	→	→	→
Polio	→	→	→
Hepatitis B	→	→	→
<b>Section B – Mandatory Other Medical Requirements</b>	<b>Did I complete?</b>	<b>Do I have the required documents attached</b>	
COVID Immunization	→	→	
<b>Section C – Mandatory NonMedical Requirements</b>	<b>Did I complete?</b>	<b>Do I have the required documents attached (certificates)?</b>	
Standard First Aid and CPR Level C Certification	→	→	
Workplace Hazardous Materials Information System (WHMIS) Certification	→	→	

Ontario Worker Health and Safety Awareness (OWHSA)	→	→
Authorization to Release Form	→	→
<b>Section D: Student Health Form Agreement</b>	<b>Did I read, sign, and date</b>	
Student Health Form Agreement	→	