Pre-Placement Health Form
Returning Student Instructions

Program Details

Program Name: **Pembroke - BScN** Code (#): 0616X Year: 3 & 4

Requirements Due: **August 1st, 2024**

Student Instructions for Mandatory Requirements

1. Review the requirements checklist below:

SECTION	REQUIREMENT	Ensure all requirements are complete with records and certificates included
Section A – Medical Requirements *(Completed and signed by Health Care Provider)*	Tuberculosis Screening	☐
	Completion of temporary exceptions	☐
	Influenza: **Due Dec. 1st, 2024**	☐
	COVID-19 (2 doses)	☐
Section B – Non-Medical Requirements	CPR HCP/BLS Certificate	☐
	N95 Mask Fit Test Certificate	☐
	WHMIS	☐
	Vulnerable Sector Police Check	☐

Access the Algonquin College Placement Pass website for the most current Pre-Placement Health Form Package: algonquincollege.placementpass.ca.

2. Book an appointment with a Physician or Nurse Practitioner
3. 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.*
4. Ensure that any requirements that were previously given a temporary exception are completed with vaccine records and lab results included.
5. Request a copy of your chest X-ray report from your health care provider if updated from last submission:
6. Complete **Section B:** Mandatory non-medical requirements
7. 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. For temporary exception completion- blood test reports and vaccine records
   c. Chest X-ray report
   d. Section B certificates or proof of completion for any non-medical requirement
8. Scan, label, and submit all documents to the Placement Pass website located at: algonquincollege.placementpass.ca.

- Fees are charged for **each submission** except for flu and COVID records.
- Verify that documents are clear and legible before submitting to the Placement Pass website.

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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. Students who previously tested negative are required to have a **repeat 1-step TB skin** test to be **completed after April 5th, 2024**. TB screening is valid for 1 year and the date is not to expire before completion of the academic year.
   ii. If a student was positive from a previous 2-step skin test, a TB skin test is not required; instead, proceed to a chest X-ray.
   iii. For any student who tested positive:
   - Complete assessment and document on form if the student is clear of signs and symptoms of active TB. (This is an annual requirement)
   - A chest X-ray is required (valid for 2 years)

   b. Proof required for completion of any vaccine series given a previous temporary exception such as polio, tetanus or hepatitis B. Updated vaccine records for dose #3 plus lab test result confirming immunity to Hepatitis B required.

   b. Influenza (Flu) – due November 24th, 2024
   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).*

   c. COVID-19
   i. Proof of vaccination is required for each dose (2 doses) 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)

Pre-Placement Health Form

SECTION A: Health Care Provider Form

! ▶ Do not leave any sections blank – If not applicable, please complete with "N/A". If drawn, provide the student with a copy of the lab report/results (attach laboratory blood report) for each of the following:

Student Name: _____ Student ID: _____

TUBERCULOSIS SCREENING *If previously negative 1-Step Mantoux Test*	**Date Administered**	**Date Read** (48-72 hours from testing)	**Results** * (Induration in mm)
1-step	YYYY/MM/DD	YYYY/MM/DD	_____ mm

*Chest X-ray results: ☐ Positive ☐ Negative ☐ N/A Date of Chest X-Ray: YYYY/MM/DD

Signs/symptoms of active TB on physical exam? ☐ Yes ☐ No Health Care Provider Initials: ( )

POLIO SERIES COMPLETION *(if applicable)*	**Dose #3**
Date Vaccine Administered:	YYYY/MM/DD

Initial primary series completed? ☐ Yes ☐ No If no, provide primary series 3 doses HCP Initials: ( )

TETANUS/DIPHTHERIA (TD) SERIES COMPLETION *(if applicable)*	**Dose #3**
Date Vaccine Administered:	YYYY/MM/DD

Initial primary series completed? ☐ Yes ☐ No If no, provide primary series 3 doses HCP Initials: ( )

HEPATITIS B SERIES COMPLETION *(if applicable)*	**Booster/ dose #4**	**Dose #5**	**Dose #6**
Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD
Product Name:			

Do lab test results one-month **post final dose** indicate "immune Hepatitis B"? ☐ Yes ☐ No ☐ N/A HCP Initials: ( )

INFLUENZA (FLU)	**Seasonal Dose**
Date Vaccine Administered:	YYYY/MM/DD
Product Name:	
Provide vaccine record or Health Care 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**: _____

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SECTION A: Health Care Provider Form

Student Name: _____ Student ID: _____

COVID-19		Dose 1	Dose 2
Full Series *Provide vaccine record*	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		
Booster Dose(s) *Provide vaccine record*	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		
COVID-19 Waiver: 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 Provider Signature & Identification		
		Professional Identification Stamp:
Printed Name:		
Signature:		
Initials:		
Designation:	☐ MD ☐ RN (EC) ☐ RN/RPN ☐PA	
Phone Number:	( ) -	

Health Care Provider Signature & Identification		
		Professional Identification Stamp:
Printed Name:		
Signature:		
Initials:		
Designation:	☐ MD ☐ RN (EC) ☐ RN/RPN ☐PA	
Phone Number:	( ) -	

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SECTION B: Mandatory Non-Medical Requirements

Student Details

Student Name: _____ Student ID (#):_____

Program Name: Pembroke - BScN Code (#): 0616X Year: 3 & 4

Yearly Requirements to remain valid until:

☐ Fall Start **(April 5th , 2025)** ☐ Winter Start ☐ Spring Start

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- Review your communication from your program to find out when to obtain these requirements including **date to apply** and any other special instructions.
- Ensure annual requirements **remain valid** until completion of your academic year (see dates above).
- Submit supporting documents in PDF format, if possible.
- Please verify that documents are clear and legible before submitting to the Placement Pass website.

NON-MEDICAL REQUIREMENTS
CPR HCP/BLS (valid for 1 year) – **Must be dated after April 5th, 2024**
Vulnerable Sector Police Check - **Must be dated after April 5th, 2024**
N95 Mask Fit Test Certificate (valid for 2 years)
WHMIS (valid for 1 year)