Pre-Placement Health Form

Student Instructions

Program Details

Program Name: **Pembroke - Practical Nursing** Code (#):1704X Year: 1

Requirements Due: **February 1st, 2025** Winter 2025

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	☐
	Measles Mumps and Rubella (MMR)	☐
	Varicella (Chicken Pox)	☐
	Tetanus/Diphtheria (Td)	☐
	Pertussis	☐
	Polio	☐
	Hepatitis B	☐
	Influenza	☐
	COVID-19 (2 doses)	☐
Section B – Non-Medical Requirements	CPR Level C Certificate	☐
	N95 Mask Fit Test Certificate	☐
	WHMIS	☐
	Vulnerable Sector Police Check	☐
	HSPnet Consent Form	☐
	Gentle Persuasive Approach (GPA)	☐
	Student Agreement	☐

2. Access the **Algonquin College Placement Pass** website for the most current Pre-Placement Health Form Package: Algonquincollege.placementpass.ca
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
   e. Signed studnt ag
9. Scan, label, and submit all documents to the 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.

Pre-Placement Health Form

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.

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)

PLACEMENT PASS by ParaMed

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 **Initial 2-Step Mantoux Test – mandatory**	**Date Administered**	**Date Read** (48-72 hours from testing)	**Results** * (Induration in mm)
1-step	YYYY/MM/DD	YYYY/MM/DD	_____ mm
2-step (7-28 days after one-step)	YYYY/MM/DD	YYYY/MM/DD	_____ mm
1- step if the initial 2-step TB skin test has been completed previously with negative results; (record date of previous 2- step in space above)	YYYY/MM/DD	YYYY/MM/DD	_____ mm

*10 mm or more: ☐ 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: ( )

MEASLES MUMPS AND RUBELLA (MMR)	**Dose 1**	**Dose 2**
Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD

Immune to MMR? ☐ Yes ☐ No Health Care Provider Initials: ( )

VARICELLA (CHICKEN POX)	**Dose 1**	**Dose 2**
Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD

Immune to Varicella? ☐ Yes ☐ No Health Care Provider Initials: ( )

POLIO	**Dose 1**	**Dose 2**	**Dose 3**
Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD

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

TETANUS/DIPHTHERIA (TD) AND PERTUSSIS	**Tdap booster**	**Dose 2**	**Dose 3**
Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD

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

HEPATITIS B		**Dose 1**	**Dose 2**	**Dose 3**	**Booster**
Initial Series	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD
	Product Name:				
Second Series	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD		
	Product Name:				

Immune to Hepatitis B? ☐ Yes ☐ No

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

Pre-Placement Health Form

SECTION A: Health Care Provider Form

Student Name: _____ Student ID: _____

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**: _____

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:	( ) -	

Pre-Placement Health Form

SECTION B: Mandatory Non-Medical Requirements

Student Details

Student Name: _____ Student ID (#):_____

Program Name: Pembroke - Practical Nursing Code (#): 1740X Year: 1

Yearly Requirements to remain valid until:

☐ Fall Start **(April 30, 2025)** ☐ Winter Start **(August 31, 2025)** ☐ 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.
- Verify that documents are clear and legible before submitting to the Placement Pass website.

NON-MEDICAL REQUIREMENTS
CPR C Certificate (valid for 1 year)
N95 Mask Fit Test Certificate (valid for 2 years)
WHMIS (valid for 1 year)
Vulnerable Sector Police Check – **must be dated after December 1st, 2024**
Gentle Persuasive Approach (GPA)
HSPnet Consent Form

Pre-Placement Health Form

Student Health Form Agreement

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 located on the student status and clearance reports, 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. If, for any reason, there is a dispute related to payment of the services, I acknowledge and agree that the authorizations granted by ParaMed may be revoked and in such case, I shall have no recourse against ParaMed in respect of the same.

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/