

**Program Details**

Program Name: **Pembroke - Practical Nursing**

Code (#):1704X

Year: 2

Requirements Due: **August 15<sup>th</sup>, 2024**

Fall 2024

**Student Instructions for Mandatory Requirements**

1. Review the requirements checklist below:

SECTION	REQUIREMENT	Ensure all requirements are complete with records and certificates included
<b>Section A – Medical Requirements</b> <i>(Completed and signed by Health Care Provider)</i>	Tuberculosis Screening	<input type="checkbox"/>
	Completion of temporary exceptions	<input type="checkbox"/>
	Influenza: <b>Due Dec. 1<sup>st</sup> 2024</b>	<input type="checkbox"/>
	COVID-19	<input type="checkbox"/>
<b>Section B – Non-Medical Requirements</b>	CPR Level C Certificate	<input type="checkbox"/>
	N95 Mask Fit Test Certificate	<input type="checkbox"/>
	WHMIS	<input type="checkbox"/>
	Vulnerable Sector Police Check	<input type="checkbox"/>

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

## 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. Students who previously tested negative are required to have a repeat 1-step TB skin test. 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)**
    - 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 (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)



# 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	Date Administered	Date Read (48-72 hours from testing)	Results * (Induration in mm)
<i>If previously negative 1-Step Mantoux Test</i>			
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 <i>(if applicable)</i>	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 <i>(if applicable)</i>	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 <i>(if applicable)</i>	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: \_\_\_\_\_

<p><b>Influenza Waiver:</b> 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 <u>implications for clinical placement and lost time</u>.</p>	<p>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.</p> <p><b>Student Signature:</b> _____</p>
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# Pre-Placement Health Form

## SECTION A: Health Care Provider Form

Student Name: \_\_\_\_\_ Student ID: \_\_\_\_\_

COVID-19		Dose 1	Dose 2
<b>Full Series</b> <i>Provide vaccine record</i>	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		
<b>Booster Dose(s)</b> <i>Provide vaccine record</i>	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	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.  <b>Student Signature:</b> _____	

Health Care Provider Signature & Identification		Professional Identification Stamp:
Printed Name:		
Signature:		
Initials:		
Designation:	<input type="checkbox"/> MD <input type="checkbox"/> RN (EC) <input type="checkbox"/> RN/RPN <input type="checkbox"/> PA	
Phone Number:	(     )     -	

Health Care Provider Signature & Identification		Professional Identification Stamp:
Printed Name:		
Signature:		
Initials:		
Designation:	<input type="checkbox"/> MD <input type="checkbox"/> RN (EC) <input type="checkbox"/> RN/RPN <input type="checkbox"/> 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 (#): 1704X Year: 2

#### Yearly Requirements to remain valid until:

- Fall Start (**April 30, 2025**)  Winter Start (**August 31, 2025**)  Spring Start

!	<ul style="list-style-type: none"> <li>▶ Review your communication from your program to find out when to obtain these requirements including <b>date to apply</b> and any other special instructions.</li> <li>▶ Ensure annual requirements <b>remain valid</b> until completion of your academic year (see dates above).</li> <li>▶ Submit supporting documents in PDF format, if possible.</li> <li>▶ Please verify that documents are clear and legible before submitting to the Placement Pass website.</li> </ul>
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NON-MEDICAL REQUIREMENTS
CPR C Certificate (valid for 1 year)
Vulnerable Sector Police Check – <b>Must be dated after May 1<sup>st</sup>, 2024</b>
N95 Mask Fit Test Certificate (valid for 2 years)
WHMIS (valid for 1 year)