

Program Details

Program Name: ECE Early Childhood Education Code (#):0430X Year:2
 Requirements Due: 9/5/2023

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 <i>(Completed and signed by Health Care Provider)</i>	Tuberculosis Screening	<input type="checkbox"/>
	Completion of temporary exceptions	<input type="checkbox"/>
	COVID-19	<input type="checkbox"/>
Section B – Non-Medical Requirements	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.

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.

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.
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)
If previously negative 1-Step Mantoux Test			
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: ○

Pre-Placement Health Form

SECTION A: Health Care Provider Form

Student Name: _____ Student ID: _____

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

Yearly Requirements to remain valid until:

- Fall Start (**August 31**) Winter Start Spring Start



- ▶ 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

Vulnerable Sector Police Check (Valid for 12 months)