# Pre-Placement Health Form

## Student Instructions

### Program and Student Details

| | | |
|---|---|---|
| **Student Name:** | **Student Number:** | |
| **Program Name:** Bachelor of Early Learning and Community Development | **Code (#):** 1617X / 1617B | **Year:** 2 to 4 |
| **Requirements Due:** | | |

### 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 (TB) Screening | ☐ |
| | Completion of Temporary Exceptions | ☐ |
| | Hepatitis B | ☐ |
| | COVID-19 (recommended) | ☐ |
| | Influenza (recommended) | ☐ |
| **Section B – Non-Medical Requirements** | Standard First Aid and CPR level C | ☐ |
| | Vulnerable Sector Check | ☐ |

2. Access the **Algonquin College Placement Pass** website for the most current Pre-Placement Health Form Package: https://algonquincollege.placementpass.ca/
3. Book an appointment with a Physician or Nurse Practitioner.
4. Provide **Section A** (instructions and forms) to your health care provider to complete and sign/stamp. RNs/RPNs may also co-sign portions of the form.
5. Ensure that any requirements that were previously given a temporary exception are completed. Ask your Health Care Provider (HCP) to provide the following documents for submission to Placement Pass with your health forms:
   a. Vaccine records (for proof of immunization).
   b. Lab blood test results.
   c. Request a copy of your chest X-ray report from your Health Care Provider if new (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 (all pages) completed, initialed, and signed by your Health Care Provider.
   b. For temporary exception completion – submit blood lab reports and vaccine records. Ensure your **NAME** is on each record.
   c. Chest X-Ray report, if required.
   d. Section B certificates or proof of completion for any non-medical requirement.
8. Scan, label, and submit all documents to the website located at https://algonquincollege.placementpass.ca/

- Verify that documents are clear and legible before submitting them to the Placement Pass.
- Ensure vaccine records that are not in English include the original document and an officially translated English copy.

# 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 (TB) 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 test is not required; instead, proceed to a chest X-ray.
     - iii. For any student who tests positive:
       - A chest X-ray is required (valid for 2 years).
       - Complete assessment and document on form if the student is clear of signs and symptoms of active TB. This is an annual requirement.
   - **b. Completion of Temporary Exceptions**
     - i. Only applicable to students cleared on temporary exceptions in the previous term.
     - ii. Proof of completion is required for any vaccine series previously granted a temporary exception (e.g., Polio, Tetanus/Diphtheria [Td], Hepatitis B).
   - **c. Hepatitis B**
     - i. Only applicable to students cleared on temporary exceptions in the previous term.
     - ii. Submit updated vaccine records confirming completion of the 3-dose series, **AND** a lab test confirming immunity (anti-HBs/HBsAb).
     - iii. If immunity is not achieved after the initial 3-dose primary series:
       - Receive a booster dose (dose #4) as soon as possible.
       - Serology is required 30 days after dose #4.
     - iv. If serology results remain < 10 IU/L after dose #4, continue the second vaccine series (dose #5 and dose #6) until completion, with repeat lab test 1 month after the final dose.
   - **d. Influenza (Flu):**
     - i. Only applicable during flu season (October to the end of April).
     - ii. Influenza vaccine is <u>strongly recommended</u> for the indicated program. 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 Section A, page 1).*
   - **e. COVID-19:**
     - i. Proof of vaccination for the primary COVID-19 vaccine series is <u>strongly recommended</u>.
     - 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 Section A, page 2).*
4. Complete Health Care Provider Signature and Identification subsection. 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 Number:** _____

| **TUBERCULOSIS (TB) SCREENING**<br>**If previous 2-step TB test was NEGATIVE** | **Date Administered** | **Date Read** (48-72 hours from testing) | **Results*** (Induration in mm) |
|---|---|---|---|
| Annual 1-step | 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 Date of Assessment: YYYY/MM/DD

Health Care Provider Initials: ( )

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

Initial primary series completed? Attach vaccination records. ☐ Yes ☐ No (If no, provide primary series of 3 doses)

Health Care Provider Initials: ( )

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

Initial primary series completed? Attach vaccination records. ☐Yes ☐No (If no, provide primary series of 3 doses)

Health Care Provider 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: | | | |

Immune to Hepatitis B? Attach lab report. ☐ Yes ☐ No

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

Health Care Provider 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.<br><br>**Student Signature**: _____ |

# Pre-Placement Health Form

## SECTION A: Health Care Provider Form

**Student Name:** _____ **Student Number:** _____

| 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**: Students who choose not to receive the COVID-19 vaccine (including recommended booster dose(s)) 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 receive the COVID-19 vaccine and recommended booster dose(s). I have chosen to waive this immunization based on medical and/or personal reasons. I am aware that I may be susceptible to COVID-19, and I understand that I may not be eligible to attend clinical placement.<br><br>**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

**Program and Student Details**

| | | |
|---|---|---|
| **Student Name:** | **Student Number:** | |
| **Program Name:** Bachelor of Early Learning and Community Development | **Code (#):** 1617X / 1617B | **Year:** 2 to 4 |
| **Requirements Due:** | | |

- ► 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.
- ► 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 |
|---|
| Standard First Aid and CPR level C |
| Vulnerable Sector Police Check – valid for 1 year |