FACULTY OF NURSING
University of Windsor

Clinical Pre-Placement Health Form

Program Name : BSCN - Collaborative Nursing

Due Date: August 10, 2012

Program Code (#)	NUR4	Program Year	Year 4	Program Descriptor	Full Time
Student Last Name:		Student First Name:		Student I.D. Number:	
Home Phone:		Cell Phone:			
Email Address:		Residential Address:			

Bring to Your Health Care Provider Appointment

- **This Form**
- **Original and photocopy of yellow immunization card or other proof of immunization.**
- **Original and photocopy of TB skin test results and completed non-medical forms.**

Hint: From your local public health unit in the area that you lived when you received high school and elementary school immunizations.

Important - Please make sure this form is completed in all of the following sections:

Section "A": Mandatory Medical Requirements: Take this form to your primary health care provider (physician or nurse practitioner). Must be completed by your health care provider (physician or nurse practitioner).

Ask your health care provider to:

- Complete all of Section "A",
- Complete all shaded areas,
- Provide you with proof of immunization and/or lab blood results for identified sections,
- Sign and date at the end of the section.

Section "B": Non - Mandatory Medical Requirements: Must be completed by you, the student.

Section "C": Non - Medical Requirements: Must be completed by you, the student.

Section "D": Student Agreement: Must be completed by you, the student.

Section "E": Completed by Requisite Program Nurse.

Complete the Checklist on the Last Page to Make Sure You Have Everything Before You Make Your Appointment With the Requisite Nurse

Requisite

Section A: Medical Requirements – Mandatory

Instructions for Physician/Nurse Practitioner: Please read carefully.

Thank you for your cooperation with the immunization process for our student registered in this program. For the protection of students, patients and external clients, students must provide documented proof of immunization. Immunization requirements listed before each section follow the standards outlined in the Canadian Immunization Guide, 7th Edition (2007), the Canadian Tuberculosis Standards (2007) and the OHA/OMA Ontario Hospitals Surveillance Protocols (revised 2010). The required information with exact dates (yy/mm/dd) and signature for each requirement must be recorded directly on this Clinical Pre-placement Health Form in the shaded areas provided . Please also provide an attesting signature at the end of the form. Failure to complete in its entirety and submit this form by the required deadline, will exclude student from their clinical/field placement.

Please ensure you have reviewed, completed and signed the required shaded areas in Section A.

Measles Mumps and Rubella (MMR)

Instructions

The Student must provide a lab blood test that indicates evidence of immunity **OR** documented proof that they have received two doses of the MMR vaccine. Copies of lab results must be provided for all three of the lab results**.**

MMR Lab Report/Results (Attach laboratory blood report for each)

Immune to MMR	Yes	No	For Requisite Nurse Use Only		
Measles	❑	❑	Lab Results Provided	Yes ❑	No ❑
Mumps	❑	❑	Lab Results Provided	Yes ❑	No ❑
Rubella	❑	❑	Lab Results Provided	Yes ❑	No ❑
OR					
MMR Vaccine Given (Dose 1)	Date:		**Must provide proof of immunization and/or immunization health record**		
MMR Vaccine Given (Dose 2)	Date:				

Health Care Provider Signature:

For Requisite Nurse Use Only	
Cleared Yes ☐ No ☐	
Exempt	☐

Tuberculosis Screening

Instructions

1) All students must have documented proof of a Two-Step TB Mantoux skin test. If proof is not available for the Two-Step Mantoux skin test or if it has not been completed previously, then the student must receive an initial Two-Step TB Mantoux skin test. The Two-Step needs to be performed **ONCE** only and it never needs to be repeated again. Any subsequent TB skin tests can be One-Step, regardless of how long it has been since the last skin test. Students who have received a BCG vaccination are **not exempt** from the initial Mantoux testing. Pregnancy is **NOT** a contraindication for performance of a Mantoux skin test.
2) Mantoux testing must be completed prior to the administration of any live vaccines (i.e. MMR, IPV) **OR** defer skin testing for 4 to 6 weeks after the vaccine is given.
3) If a student was **positive** from a previous Mantoux Two-Step skin test and/or has received TB treatment, the health care provider must complete an assessment and document below if student is free from signs and symptoms of active tuberculosis.
4) Any student who has proof of a previous **negative** Two-Step, must complete a One-Step.
5) For any student who tests positive for the first time:

a. Include results from the positive Mantoux screening (mm of induration),

b. A chest x-ray is required and the report must be enclosed in this package,

c. Indicate any treatments that have been started,

d. Complete assessment and document on form if the student is clear of signs and symptoms of active TB,

e. The responsibility for follow up lies with the health care provider as per the OHA/OMA Communicable Disease Surveillance Protocols.

Results

Initial Two-Step TB Test Mantoux – Mandatory	Date Given	Date Read (48-72 hours from testing)	Result: Induration in mm	Must provide proof of Mantoux One-Step and Two-Step TB skin test results
One-Step				
Two-step (7-21 days after one-step)				
Annual One-Step (If the initial Two-step TB skin test has been completed with negative results, complete one-step only)				Must provide proof of Mantoux One-Step TB skin test results

If either step is positive (10 mm or more), please evaluate the following

1)	Chest x-ray Results:	❑	Positive	❑	Negative	❑	N/A	Date:	
2)	History of Disease?	❑	Yes	❑	No				
3)	Prior History of BCG Vaccination?			❑	Yes	❑	No	Date:	
4)	INH prophylaxis?	❑	Yes	❑	No	Dosage:		Duration:	
5)	Specialist referred?	❑	Yes	❑	No				
6)	Does this student have signs and symptoms of active TB on physical exam?					❑	Yes	❑	No
Health Care Provider Signature:								Date:	

For Requisite Nurse Use Only	
Chest X-ray Provided	
Yes ❑	No ❑
Cleared	
Yes ❑	No ❑

Varicella (Chicken Pox)

Instructions

The Student must provide documented history of varicella. If no history of varicella, the student must provide **EITHER** proof of varicella vaccine **OR** must provide a lab blood test that indicates evidence of immunity. This vaccine is not recommended (contraindicated) for pregnant women. Pregnancy should be avoided for three months after a Varicella vaccination has been given.

Varicella	Yes	No	For Requisite Nurse Use Only		
Documented history of Varicella **Date(s):**_____	❑	❑	Dates provided	Yes ❑	No ❑
If no documented history of Varicella must provide proof of receiving varicella vaccine or provide lab blood test					
Varicella Vaccine Given (Dose 1)	Date:		**Must provide proof of Varicella immunization and/or attach immunization health record**		
Varicella Vaccine Given (Dose 2)	Date:				
Lab Report/Results (Attach laboratory blood report)	**Yes**	**No**	**For Requisite Nurse Use Only**		
Immune	❑	❑	Lab Results Provided	Yes ❑	No ❑

Health Care Provider Signature:

For Requisite Nurse Use Only	
Cleared Yes ☐ No ☐	
Exempt	☐

Tetanus/Diphtheria (Td)

Instructions

1) Date and proof of initial primary series completed within the last 10 years **OR** date and proof of booster.
2) If no previous immunization give: 2 doses, 4 to 8 weeks apart and 3rd dose 6 to 12 months later.

	Yes	No	
Initial primary series completed	❑	❑	**Must provide proof of Tetanus/Diphtheria immunization and/or attach immunization health record**
Booster completed	❑	❑	
Initial primary series completed	Date:		
Booster completed	Date:		
If required for primary vaccination			
Tetanus/Diphtheria (Td) Given (Dose 1)	Date:		**Must provide proof of Tetanus/Diphtheria immunization and/or attach immunization health record**
Tetanus/Diphtheria (Td) Given (Dose 2)	Date:		
Tetanus/Diphtheria (Td) Given (Dose 3)	Date:		

Health Care Provider Signature:

For Requisite Nurse Use Only	
Cleared	
Yes ❑	No ❑

Pertussis

Instructions

If student has not received Pertussis vaccine as an adolescent or adult – they require an Adacel or equivalent Vaccination.

	Yes	No	
Initial immunization complete	❑	❑	**Must provide proof of Pertussis immunization and/or attach immunization health record**
If "Yes" provide date	Date:		
If "No" Adacel or equivalent given	Date:		

Health Care Provider Signature:

For Requisite Nurse Use Only	
Cleared	
Yes ❑	No ❑

Polio

Instructions

Provide date and proof of completed initial primary series.

	Yes	No	
Initial primary series completed	❑	❑	**Must provide proof of Polio immunization and/or attach immunization health record**
Initial primary series completed	Date:		

Health Care Provider Signature:

For Requisite Nurse Use Only	
Cleared	
Yes ❑	No ❑

Hepatitis B

Instructions

1) A Lab blood test must be obtained for evidence of immunity. **Copies of lab results must be provided**.
2) If the student has documentation of a completed initial primary series and serology results are < 10 IU/L, provide a booster dose and complete another lab test 1 month following the booster. Students must provide documented proof that they have received the initial primary series for Hepatitis B vaccine.
3) If the student has not received the Hepatitis B vaccine and serology results are < 10 IU/L, 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 1 month following dose # 3

Mandatory Lab Reports/Results

Previous initial primary series for Hepatitis B completed	**Yes**	**No**	**Must provide proof of immunization and/or attach immunization health record. Attach laboratory blood report**		
If "Yes" provide dates	❑	❑			
Date of completion	Date:				
Immune - Hepatitis B Lab Serology Results	**Yes**	**No**	**For Requisite Nurse Use Only**		
Hepatitis B	❑	❑	Lab Results Provided	Yes ❑	No ❑
If "No" (Initial Primary Series)					
Hepatitis B Vaccine Given (Dose 1)	Date:				
Hepatitis B Vaccine Given (Dose 2)	Date:				
Hepatitis B Vaccine Given (Dose 3)	Date:				
Immune - Hepatitis B Lab Serology Results	**Yes**	**No**	**For Requisite Nurse Use Only**		
Hepatitis B	❑	❑	Lab Results Provided	Yes ❑	No ❑

Health Care Provider Signature:

For Requisite Nurse Use Only	
Cleared Yes ☐ No ☐	
Exempt	☐

To Be Completed By The Health Care Provider Physician / Nurse Practitioner / Registered Nurse:
Please complete shaded area below OR provide professional identification stamp.

Signature:		MD/ RN (EC) / RN
Initials:		
Print Name:		
Phone Number:		

Stamp Area

Section "B" – Other Medical Requirements

Influenza: Strongly Recommended

Instructions

To be completed by student. Influenza Vaccination (Flu Shot): Annual Immunization Vaccine Only Available During Flu Season (October/November). All Students are encouraged to protect themselves with annual influenza immunization. Students who have not received the vaccination may be removed from clinical placement as some of our placement partners may require that students receive influenza immunization and show proof especially if there is an outbreak. **In the event of an outbreak at your placement, any student without the vaccination may be denied access to the facility thereby jeopardizing successful completion of the clinical course. Proof of flu vaccine can be faxed or scanned and emailed to ParaMed.**

Results	Date
Seasonal Flu Vaccine received:	
Other Vaccine received:	

✶Provide proof of immunization and/or immunization health record. Proof of Influenza immunization can be faxed to the Requisite Program at 519-972-8813 or scanned to windsor@paramed.com.

****Please note that annual immunization vaccine is only available during Flu Season (October/November).**

For Requisite Nurse Use Only	
Cleared	
Yes ❑	No ❑
Document Provided	
Yes ❑	No ❑

Influenza Waiver Students who choose not to have the annual influenza vaccine for medical or personal reasons must sign a waiver that acknowledges their awareness of susceptibility to the disease and of the implications for clinical placement and lost time. Students must provide consent for the school to communicate their influenza immunization status to the clinical agency in which they are placed. 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. I consent to have my program communicate my influenza status to clinical agencies.

Student Signature:		Date:	

Section "C" – Mandatory Non-Medical Requirements

Non-Medical Requirements

Instructions for Students

As a student accepted in this program, you are required to complete the following non-medical requirements.

1) Review your communication package to find out how and where to obtain these requirements,
2) Locate the approved sources to obtain the requirement(s),
3) Obtain the certificate/proof of completion,
4) If pregnant and plan to obtain Mask Fit test from ParaMed, must have medical clearance (a note) from health care practitioner
5) For each of the non-medical requirement(s), bring the original and one copy of your certificate and/or proof of completion to your Requisite appointment.

If you have previously obtained one or more of the above non-medical requirements, please ensure they have not expired (if applicable).

Non Medical Requirements	Date Issued	Expiry Date	For Requisite Nurse Use Only			
			Document Provided		Cleared	
			Yes	No	Yes	No
CPR Level HCP Certificate Card (Annual Recertification)			❑	❑	❑	❑
Vulnerable Sector Police Check (annual) **AND** Photo ID required with birthdate (e.g. Driver's License)			❑	❑	❑	❑
Student WSIB Declaration Waiver (annual)			❑	❑	❑	❑
Attestation of Clear Criminal Record (annual)			❑	❑	❑	❑
Student Verification of Health Status (annual)			❑	❑	❑	❑

Section "D" – Student Agreement

Section D - The Student 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 Ontario Hospital Association protocol, I need to demonstrate that certain health standards have been met in order for me to be granted student placement .

I understand that I must have all sections of this form fully completed and reviewed by the ParaMed Requisite Program 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. 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.

Student 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.

Section "E" – To be completed by Requisite Nurse

To be completed by Requisite Nurse

Pre-placement Requirement Status			
Cleared	**Yes**	**No**	**Date**
	❑	❑	
Exception	❑	❑	
Date:			
Nurse Signature:			
Nurse Name (Print):			

Stamp Pad - ParaMed Requisite Office Use Only

Student Checklist - Is My Clinical Pre-placement Health Form Completed?

PLEASE USE THIS CHECKLIST AS YOU COLLECT YOUR DOCUMENTATION AND PREPARE FOR YOUR PARAMED APPOINTMENT.

Bring to your Requisite Appointment

- **This Form completed,**
- **Blood lab reports -as required -see below**
- **Yellow immunization card and copy or other proof of immunization and copies. (Hint: From your local public health unit in the area that you lived when you received high school and elementary school immunizations),**
- **Provide photocopy of all documents.**

Section "A" - Mandatory Medical Requirements:	Was section "A" completed by Physician or Nurse Practitioner?		Was it signed by Physician or Nurse Practitioner?		Do I have all the required documents attached? (proof of immunization/blood Lab report)	
	Yes	No	Yes	No	Yes	No
Measles Mumps and Rubella (MMR)	❑	❑	❑	❑	❑	❑
Tuberculosis Screening	❑	❑	❑	❑	❑	❑
Varicella (Chicken Pox)	❑	❑	❑	❑	❑	❑
Tetanus/Diphtheria (Td)	❑	❑	❑	❑	❑	❑
Pertussis	❑	❑	❑	❑	❑	❑
Polio	❑	❑	❑	❑	❑	❑
Hepatitis B	❑	❑	❑	❑	❑	❑

Section "B" - Other Medical Requirements:	Did I complete?		Are the required Documents Attached?	
	Yes	No	Yes	No
Influenza	❑	❑	❑	❑

Section “C” Mandatory Non-Medical Requirements:	Did I complete?		Do I have the required documents attached (certificates) ?	
	Yes	No	Yes	No
CPR Level HCP Certificate Card (Annual Recertification)	❑	❑	❑	❑
Vulnerable Sector Police Check (annual) **AND** Photo ID required with birthdate (e.g. Driver's License)	❑	❑	❑	❑
Student WSIB Declaration Waiver (annual)	❑	❑	❑	❑
Attestation of Clear Criminal Record (annual)	❑	❑	❑	❑
Student Verification of Health Status (annual)	❑	❑	❑	❑

Section “D” Student Agreement:	Did I read and sign/date?	
	Yes	No
Student Agreement	❑	❑