ST. CLAIR COLLEGE
OF APPLIED ARTS & TECHNOLOGY

Program: _____ Student I.D. _____

Name: _____
(Surname) (First name) (Middle initial)

Email: _____ Home Phone: _____ Cell Phone: _____

Returning Students- Health Form Medical Requirements (Nursing only)

(To be completed by PHYSICIAN or NURSE PRACTITIONER)

NOTE TO STUDENT: If you have documentation of the following immunizations, please bring proof of the documentation/yellow immunization card with this form to your physician or nurse practitioner.

Hint: You may want to start with your local public health unit in the area that you lived when you received high school and elementary school immunizations.

Section "A" --Tuberculosis Screening

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.

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.

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.

Any student, who has proof of a previous **negative** Two-Step, must complete a One-Step.

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.

Initial 2 Step TB Test – Mandatory (2nd step to be administered)-read 48-72 hrs. after given

Two Step (7-21 days after 1 step)- Date Given _____ Date Read:_____ Result: Induration in mm:_____

Annual One Step- Date Given_____ Date Read: _____Result: Induration in mm:_____

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

Chest x-ray results: Date_____Positive_____ Negative_____

History of disease: Yes_____No_____

Tuberculosis Screening

Prior History of BCG vaccination: Yes_____ No_____ Date _____
Specialist referred Yes_____ No_____
INH prophylaxis: Yes_____ No_____ Dosage:_____ Duration_____
Does this student have signs and symptoms of active TB on physical exam: Yes_____ No___?

Section B- Influenza **(STRONGLY RECOMMENDED)** **Vaccine available Oct or Nov; student may fax documentation to ParaMed upon receipt of vaccine.*

Seasonal Vaccine Date: _____ (Yearly update)
Other Vaccine Type: _____ Date: _____

INFLUENZA WAIVER Students who choose not to have the annual influenza vaccine for medical or personal reason must sign a waiver that acknowledges their awareness and 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 the annual influenza vaccine. I have selected to waive this immunization based on medical/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_____

The above recommendations are based on Ontario Guidelines for Immunization. If you do not feel it is necessary or advisable at this time to administer one or any of the vaccines listed above, please note the reason(s) for this:

Signature of Physician or Nurse Practitioner:

Date: