Clinical Pre-Placement Health Form

Program Name : Pharmacy Technician Due Date:

Program Code (#)	5850	Program Year	Year 1	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**
- **Yellow immunization card**
- **Other proof of immunization**

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": Other - 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

Section "A" Medical Requirements

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, 6th Edition, the Canadian Tuberculosis Standards and the OHA/OMA Ontario Hospitals Surveillance Protocols. 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

A lab blood test must be obtained for evidence of immunity. **Copies of lab results must be provided for all three of the mandatory lab results.** A MMR vaccine is required if there is a negative, non-reactive, or indeterminate MMR titre lab results. The Student must provide documented proof that they have received the MMR vaccine. If an MMR vaccine is given, repeat lab work in 6 – 8 weeks and **provide a copy of the lab results** (numerical values).

Mandatory 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 ❑
If required					
MMR Vaccine Given (Dose 1)	Date:		**If MMR vaccine given, must provide proof of immunization and/or immunization health record**		
MMR Vaccine Given (Dose 2) **OR**	Date:				
MMR Booster Given	Date:				
Mandatory Lab Report/Results (must attach)	**Yes**	**No**	**For Requisite Nurse Use Only**		
Immune to MMR	❑	❑	Lab Results Provided	Yes ❑	No ❑

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.

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 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)				

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	
Cleared	
Yes ❑	No ❑

Varicella (Chicken Pox)

Instructions

A Lab blood test must be obtained for evidence of immunity. Copies of lab blood results must be provided. The Varicella vaccine is required if lab reports show no immunity. If a Varicella vaccine is given, repeat lab work in 6 – 8 weeks and provide a copy of the lab results (numerical values). This vaccine is not recommended for pregnant women. Pregnancy should be avoided for three months after a Varicella vaccination has been given.

Mandatory Lab Report/Results (Attach laboratory blood report)

Immune	**Yes**	**No**	**For Requisite Nurse Use Only**		
Varicella	❑	❑	Lab Results Provided	Yes ❑	No ❑
If blood results indicate no immunity provide student with Varicella vaccine					
Varicella Vaccine Given (Dose 1)	Date:		**Must provide proof of Varicella immunization and/or attach immunization health record**		
Varicella Vaccine Given (Dose 2)	Date:				
Post Vaccination 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 completion **OR** date and proof of most recent booster given.
2) If more than 10 years since last initial primary series or booster, repeat booster.

	Yes	**No**	
Initial Primary series completed (or)	❑	❑	**Must provide proof of Tetanus/Diphtheria immunization and/or attach immunization health record.**
Booster completed	❑	❑	
Initial primary series completed	Date:		**Please Note: It is the Students responsibility to ensure they complete all initial primary series doses (3) for subsequent years.**
Booster given	Date:		

Health Care Provider Signature:

For Requisite Nurse Use Only	
Cleared	
Yes ❑	No ❑

Polio

Instructions

Date and proof of completed initial primary series or last Polio booster within the last 10 years is required. If no previous immunized, then give: 2 doses, 4 to 8 weeks apart.

	Yes	**No**	
Initial primary series completed	❑	❑	**Must provide proof of Polio immunization and/or attach immunization health record**
Booster completed	❑	❑	
Initial primary series completed	Date:		**Please Note: It is the Students responsibility to ensure they complete all required doses initial series doses (3) for subsequent years.**
Booster given	Date:		
If "No" give initial primary series			
Polio Given (Dose 1)	Date:		
Polio Given (Dose 2) at 4 to 8 weeks	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	☐

Section "B" – Other Mandatory Medical Requirements

Influenza: Mandatory

Instructions

To be completed by student. Influenza Vaccination (Flu Shot): Annual Immunization Vaccine Only Available During Flu Season (October/November).

Results	Date	✶Provide proof of immunization and/or immunization health record. Proof of Influenza immunization can be faxed to the Requisite Program
Seasonal Flu Vaccine received:		
Other Vaccine received:		

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

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) 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)			❑	❑	❑	❑
Standard First Aid (Every three years) Certificate Card			❑	❑	❑	❑
Vulnerable Sector Police Check (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, Regulation

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

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

Bring to your Requisite Appointment

- **This Form completed,**
- **Blood lab reports -as required -see below**
- **Yellow immunization card or other proof of immunization (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)	❑	❑	❑	❑	❑	❑
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	❑	❑	❑	❑
Standard First Aid	❑	❑	❑	❑
Vulnerable Sector Police Check	❑	❑	❑	❑

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