

Clinical Pre-Placement Health Form

Program Name :

Paramedic

Due Date:

Program Code (#)	9101	Program Year	Year 2	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: Not Applicable

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

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

The Student must provide documented proof that they have received the MMR vaccine.

Previous MMR immunization record indicates MMR vaccine was given	Yes	No	Must provide proof of MMR immunization and/or immunization health record
	<input type="checkbox"/>	<input type="checkbox"/>	
MMR Vaccine Given (Dose 1)	Date:		
MMR Vaccine Given (Dose 2)	Date:		
If "No" Student must receive MMR vaccine (2 doses)			
MMR Vaccine Given (Dose 1)	Date:		
MMR Vaccine Given (Dose 2)	Date:		

Health Care Provider Signature:

For Requisite Nurse Use Only	
Cleared	Yes <input type="checkbox"/> No <input type="checkbox"/>
Exempt	<input type="checkbox"/>

Tuberculosis Screening

Instructions

- 1) If student has had previous proof of a negative Step-Two, any subsequent Tuberculosis skin testing (TST) can be one-step, regardless of how long it has been since the last TST. Student who have received a BCG vaccination are **not exempt** from Mantoux tes
- 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) For any student who tests positive for the first time:
 - a. Include results from the positive Mantoux screening (mm of induration),
 - b. Complete assessment and document on form if the student is clear of signs and symptoms of active TB,
 - c. The responsibility for follow up lies with the health care provider as per the OHA/OMA Communicable Disease Surveillance Protocols.

Results

One-Step TB Skin Testing (annually)	Date Given	Date Read (48-72 hours from testing)	Result: Induration in mm			Must provide proof of One-Step TB skin test results
Step-One						
Does this student have signs and symptoms of active TB on physical exam?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Health Care Provider Signature:			Date:			

For Requisite Nurse Use Only

Cleared

Yes ☐ No ☐

Hepatitis B

Instructions

Students are to provide documented proof that they have received the initial Hepatitis B primary series (3 doses).

Mandatory Lab Reports/Results

	Yes	No	Must provide proof of immunization and/or attach immunization health record. Attach laboratory blood report		
Previous initial primary series for Hepatitis B completed	<input type="checkbox"/>	<input type="checkbox"/>			
If "Yes" provide date of completion initial primary series (3 doses)	Date:				
Immune - Hepatitis B Lab Serology Results	Yes	No	For Requisite Nurse Use Only		
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Lab Results Provided	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Health Care Provider Signature:

For Requisite Nurse Use Only

Cleared Yes ☐ No ☐

Exempt ☐

To Be Completed By The Health Care Provider Physician / Nurse Practitioner:

Please complete shaded area below OR provide professional identification stamp.

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

Stamp Area

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 <input type="checkbox"/>	No <input type="checkbox"/>
Document Provided	
Yes <input type="checkbox"/>	No <input type="checkbox"/>

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)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mask Fit Testing (annual)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vulnerable Sector Police Check (annual)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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			
	Yes	No	Date
Cleared	<input type="checkbox"/>	<input type="checkbox"/>	
Exception	<input type="checkbox"/>	<input type="checkbox"/>	
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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section "B" - Other Medical Requirements:	Did I complete?		Are the required Documents Attached?	
	Yes	No	Yes	No
Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mask Fit Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vulnerable Sector Police Check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section "D" Student Agreement:	Did I read and sign/date?	
	Yes	No
Student Agreement	<input type="checkbox"/>	<input type="checkbox"/>