Clinical/Field Pre-Placement Health Form

Program Name: Practical Nursing **Program Code (#)**: 1704X
Program Year: Year 2

Student Information
Last Name: **First Name**: **Student I.D. Number**:
Email: **Home Phone**: **Cell Phone**:
Residential Address:

Bring to Your Health Care Provider Appointment

1. This form.
2. Yellow immunization card and/or regional health unit forms that denote record of your immunization history.
3. Other proof of immunization such as blood tests and/or lab results.

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: to be completed by your health care provider (Physician, Nurse Practitioner or Registered Nurse)

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 Medical Requirements: Must be completed by you, the student.
Section C: Mandatory 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 the 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 at Algonquin.requisite.ca.

Section A: Medical Requirements – Mandatory

Instructions for Physician/Nurse Practitioner/ Registered Nurse: 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, Evergreen Edition, Part 4, Active Vaccines (2012), the Canadian Tuberculosis Standards (2007) and the OHA/OMA Ontario Hospitals Communicable Disease 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.

Requisite

ALGONQUIN COLLEGE

Tuberculosis Screening

Instructions:
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 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 30 days weeks after the vaccine is given.

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

Annual Step-One TB Skin Test	**Date Given**	**Date Read** (48-72 hours from testing)	**Results** (Induration in mm)
One-Step			

Note: Must provide proof of Mantoux One-Step TB skin test results.

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

1. Chest x-ray results: ❑ Positive ❑ Negative ❑ N/A Date:_____
2. INH prophylaxis? ❑ Yes ❑ No Dosage:_____ Duration:_____
3. Specialist referred? ❑ Yes ❑ No
4. Does this student have signs and symptoms of active TB on physical exam? ❑ Yes ❑ No

Health Care Provider Initials:_____ Date:_____

For Requisite Nurse Only	**Yes**	**No**
Chest x-ray provided	❑	❑
Cleared	❑	❑

To be completed by the health care provider.
Please complete the shaded area below OR provide professional identification stamp.

Signature: _____

Designation (circle one): **MD** **RN(EC)** **RN**

Initials: _____

Print Name: _____

Phone Number: _____

Stamp Area

Signature: _____

Designation (circle one): **MD** **RN(EC)** **RN**

Initials: _____

Print Name: _____

Phone Number: _____

Stamp Area

Section B: Other Medical Requirements

Influenza: Strongly Recommended

Instructions:
Influenza Vaccination (Flu Shot): 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 emailed to ParaMed at** cburke@paramed.com.

Results:
Seasonal flu vaccine received on date: _____
Other vaccine received: _____

For Requisite Nurse Only	Yes	No
Document provided	❑	❑
Cleared	❑	❑
Exception	❑	❑

For Student to Sign only when they choose to NOT receive the flu vaccine: Influenza Waiver
Students who choose not to have the annual influenza vaccine for medical or personal reasons must sign below to acknowledge 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.

Signature: _____

Print Name: _____

Date: _____

Section C: Mandatory 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.
6) Complete the shaded columns only. The last two columns are for Requisite Nurse Use Only.

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	Document Provided	Cleared
CPR Level C Certificate Card (annual recertification)			❑	❑
Standard First Aid (every three years) Certificate Card			❑	❑
Mask Fit Testing (completed every two years)			❑	❑
Vulnerable Sector Police Check (annual)			❑	❑
Student Agreement for Clinical/Field Placement			❑	❑

Section D: Student Health Form Agreement

Section D - The Student Health Form 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 the faculty in my educational program will be able to view the results from this form.

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.

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

Initial Visit

Pre-placement Requirement Status	Yes	No	Date	Stamp – ParaMed Requisite Office Use Only
Cleared	❑	❑		
Exception	❑	❑		
Agreement Form	❑	❑		

Nurse Signature: _____

Nurse Name (Print): _____

Date: _____

Data entered into Requisite Software by: _____

Date: _____

Subsequent Visit

Pre-placement Requirement Status	Yes	No	Date	Stamp – ParaMed Requisite Office Use Only
Cleared	❑	❑		
Exception	❑	❑		
Agreement Form	❑	❑		

Nurse Signature: _____

Nurse Name (Print): _____

Date: _____

Data entered into Requisite Software by: _____

Date: _____

Is My Clinical/Field Pre-placement Health Form Completed? – Checklist

Bring to your Requisite appointment:

- This form.
- Your blood lab reports – as required.
- Your yellow immunization card or other proof of immunization (Hint: obtain from your local public health unit in the area that you lived when you received high school and elementary school immunizations.)
- A photocopy of all documents.

Section A– Mandatory Medical Requirements	**Was Section A completed by the health care provider?**	**Was it signed by health care provider?**	**Do I have all the required documents attached?** (proof of immunization/blood lab report)
Tuberculosis Screening	❑	❑	❑

Section B – Other Medical Requirements	**Did I complete all sections**	**Are the required documents attached**
Influenza Immunization	❑	❑

Section C – Mandatory Non-Medical Requirements	Did I complete?	Do I have the required documents attached (certificates)?
CPR Level C Certificate Card (annual recertification)	❑	❑
Standard First Aid (every three years) Certificate Card	❑	❑
Mask Fit Testing (completed every two years)	❑	❑
Vulnerable Sector Police Check (annual)	❑	❑
Student Agreement for Clinical/Field Placement	❑	❑

Section D – Student Health Form Agreement	Did I read, sign, and date
Student Health Form Agreement	❑