ST. CLAIR COLLEGE

Directions for Completing Medical Requirement Forms (Paramedic)(2018)

Ontario regulations and St. Clair College Policy require health-screening for persons entering a clinical/field placement setting in School of Health Sciences Paramedic Program.

The student's acceptance into the program is conditional upon the completion of the enclosed forms. ***STUDENT RESPONSIBILITY*** **You must closely follow these directions.** **No student will be allowed to go into a clinical placement without completing these requirements. Students should keep copies of completed forms for their records. They will be needed for employment purposes.**	**Health History** ☐ Complete the page, sign and date at bottom **Immunization/Communicable Disease Record** ☐ Complete ***top*** portion of the page ☐ Provide proof of immunization history ☐ If you have had a negative TB skin test in the previous 12 months- proof of this must be provided. **Pre-Entrance Health Examination** ☐ Fill in demographic information at the top of page
We recommend that you make appointment with your Physician: as soon as you receive this form.	**NOTE: This process may take 2 months to complete**
PHYSICIAN ONLY If you have any questions about the forms or requirements, please contact the Campus Nurse: Windsor at (519) 972-2380 or Chatham at (519) 354-9100 ext. 3229. ** If there is a record of a previous *negative TB skin test in the past 12 months*, only one more TB skin test needs to be done.	**Health History** ☐ Review any problem areas with student **Immunization/Communicable Disease Record** ☐ Administer **2** TB skin tests (minimum 1 week apart) **NOTE: A 2-step TB skin test is MANDATORY** ** ☐ Test for Measles, Mumps, Rubella, and Varicella titres and for Hepatitis B antibodies **MANDATORY** ☐ Administer vaccines if needed ☐ Certify that student is free of symptoms of reportable communicable diseases (sign & date) **Pre-Entrance Health Examination** ☐ Record your findings ☐ Complete physical ability clearance section ☐ Include the office stamp with your name, address and phone number ☐ Sign and date at the bottom of the form
ST. CLAIR COLLEGE HEALTH CENTRE RESPONSIBILITY	**Passport to Health** ☐ Review records and validate that all requirements have been met according to SCC policy. ☐ Issue a "Passport" if all requirements are complete

All information contained in the medical requirement forms will be held with strictest confidence in the St. Clair College Health Centre. It is not shared with anyone outside of the St. Clair College Health Centre without the student's written consent. In the event that the student has a medical emergency or requires medical or nursing attention at the college, the information will assist the Health Centre staff to provide safe and appropriate care to the student. *July 2016*

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HEALTH HISTORY

(This page to be completed by STUDENT and reviewed by Physician)

Name:_____ Student I.D. #_____ Date of Birth:_____

Address:_____ City/Prov/PC:_____ Home Phone:_____

Health Card#_____ Version Code:_____ Cell #_____

Emergency Contact (Name/Relationship/Tel. #):_____ E-mail:_____

Family History

Please check if you or any relative (parents, grandparents, siblings, or children) have had any of the following conditions:

____High blood pressure	____Kidney disease	____Asthma
____Stroke	____Bleeding tendencies	____Tuberculosis
____Cancer	____Seizures	____Colitis
____Emphysema	____Heart disease	____Anemia
____Ulcers	____Diabetes	____Other serious illness (specify):_____
____Mental illness	____Gout	_____

Lifestyle

What is your sleep pattern?_____ Do you feel rested?_____

Appetite: Poor Fair Good 24hr. Diet Recall:_____

Do you: Smoke?_____ Packs per day:_____ # of years smoked:_____

Drink Alcohol?_____ Drinks per day/week:_____

Drink/eat caffeine products?_____ Amount per day:_____

Use any recreational drugs?_____ Frequency:_____

Exercise?_____ Type:_____ Frequency:_____

Current Health Status

Do you currently have any health problems? If yes, please list:_____

Are you currently taking any medication? If yes, please list:_____

Do you have any allergies? If yes, please list:_____

Personal Illness/Injury History

Childhood illness, adult illnesses, medical conditions, and surgeries:_____

Previous accidents or injuries that you have had:_____

- **I hereby certify that the above information I have given is correct and that I have no other conditions that might affect my ability to fulfill my placement responsibilities.**

Signature of Student:_____ **Date**:_____

- **I hereby give permission to St. Clair College Health Centre to release information regarding my immunization status to the field placement agency to which I am assigned for my practical experience.**

Signature of Student:_____ **Date**:_____

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Program:_____ Student I.D. #_____

Name:_____

(Surname) (First name) (Middle initial)

NOTE TO STUDENT: If you have documentation of the following immunizations, please bring proof of the documentation with this form to your physician.

VACCINE PREVENTABLE DISEASE IMMUNIZATION FORM

VACCINE	REQUIREMENT	DATES OF IMMUNIZATION	SEROLOGY
Tetanus/Diphtheria	**Primary series of 3** **Update every 10 years**	**#1** **#2** **#3** **Last booster:**	**N/A**
Pertussis	**Single dose of Tdap in adulthood**	**#1**	**N/A**
Polio (IPV)	**Primary series of 3**	**#1** **#2** **#3**	**N/A**
Varicella	**If no immunity- 2 doses of Varivax required**	**#1** **#2**	**Date:** **Results:**
Measles **Mumps** **Rubella**	**Primary series of 2 MMR**	**#1** **#2**	**Date:** **Results:** **Results:** **Results:**
Hepatitis B	**Primary series of 3**	**#1** **#2** **#3**	**Date:** **Results:**

The above recommendations are based on Ontario guidelines for Immunization.

I certify that as of this date, the student is free of any symptoms of active illness of any reportable communicable diseases.

Physician's Signature:

_____

Date: _____

The signing physician acknowledges all of the above information as true to the best of their knowledge.

Physician's Stamp Below:

NOTE: PHL SEROLOGY REPORT MUST BE ATTACHED

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PRE-ENTRANCE HEALTH EXAMINATION

(This page to be signed by PHYSICIAN ONLY)

Name:_____ Date of birth:_____ Sex: M / F

Height: _____ Weight:_____ Blood Pressure:_____/_____ Temp:_____ Pulse:_____ Resp:_____

Vision: R 20/_____ L 20/_____ Corrected: Y / N Contacts: Y / N Glasses Y / N Hearing: R_____ L _____

	Normal	Abnormal Findings	Comments
Head/ Neck			
Eyes/ Sclera/Pupils			
Ears			
Nose/Mouth/Throat			
Lymph Nodes			
Heart: Sounds/Rhythm			
Peripheral Vascular			
Lungs			
Chest contour			
Skin			
Abdomen			
Hernia			
Neck/Back/Spine: Alignment / ROM			
Neuro-musculo-skeletal Upper extremities Lower extremities			
Reflexes			
Balance + coordination			
Posture			
Psychosocial/Mental			

PHYSICAL ABILITY CLEARANCE:

In your opinion, is this individual capable of performing functions such as lifts/transfers/restraint protocols for all age groups/or carries safely? Y / N

Person may participate in the following activities:
___Walking ___Running ___Lifting ___Bending

At the following level:
___Light ___Moderate ___Strenuous

If the person is NOT CLEARED for participation in any activities, please give reason:_____

_____

If person has medical restrictions, please list restrictions:_____

_____

I certify that this student **IS / IS NOT** **physically *and* mentally fit** to undertake the duties of his/her program.

Office Stamp (Name, Address, Phone Number)	
	_____ _____ **Signature of Physician** **Date of Exam**

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NAME_____ **STUDENT #**_____

Immunization/Communicable Disease Record

(To be completed by PHYSICIAN)

Initial 2 Step TB Test- Mandatory (2nd step to be administered 7-21 days after 1 step)

Date administered #1-_____ +____mm / -____ Date Read:_____ Init:_____

Date administered #2-_____ +____mm / -____ Date Read:_____ Init:_____

**** If there is a record of a previous negative TB skin test in the past 12 months, only one more TB skin test needs to be done.**

Please provide documentation of the previous TB test .

*** If there is a record of a previous positive TB skin test, a chest x-ray must be done.**

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

1. **Chest x-ray results: Date_____ Positive_____ Negative_____**
2. **History of disease: Yes_____ No_____**
3. **Documentation of BCG vaccination: Date_____**
4. **Public Health Unit referral; Yes_____ No_____ Specialist referral_____**
5. **INH prophylaxis: Yes_____ No_____ Dosage:_____ Duration_____**
6. **Does this student have signs and symptoms of active TB on physical exam:**
   - **Fatigue..... YES • NO •**
   - **Fever..... YES • NO •**
   - **Night sweats..... YES • NO •**
   - **Weight loss..... YES • NO •**
   - **Coughing..... YES • NO •**
   - **Blood tinged sputum.. YES • NO •**
   - **Hoarseness ..... YES • NO •**
   - **Chest pain..... YES • NO •**

Signature of Physician _____ Date:_____