Directions for Completing Medical Requirement Forms (2018)

In accordance with the Current Ontario Hospital Association Communicable Diseases Surveillance Protocols and the Canadian Immunization Guide

The student’s acceptance into the clinical/field placement is conditional upon the completion of the enclosed forms.

**STUDENT RESPONSIBILITY**

You must closely follow these directions.

Bring your immunization record to first visit

Please call your local public health unit for your immunization record

We recommend that you make appointment with Physician or Nurse Practitioner as soon as you receive this form.

**PHYSICIAN / NURSE PRACTITIONER RESPONSIBILITY**

If you have any questions about the forms or the requirements, please contact the Campus Nurse: in Windsor at (519) 972-2380 or in Chatham at (519) 354-9100 ext. 3800.

* TB skin testing is not required for students who have had a previously positive TB skin test. A chest x-ray will be required.

** 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 if documentation is provided.

**NOTE: This process may take 2 months to complete**

**ST. CLAIR COLLEGE HEALTH CENTRE RESPONSIBILITY**

PrePlacement Medical Clearance by HEALTH CENTRE STAFF

- Review records and validate that all requirements have been met according to Ontario Guidelines
- Issue a “Passport to Health” if all requirements are complete

**Health History**

- Complete the page, sign and date at bottom

**Immunization/Communicable Disease Record**

- Complete top portion of both pages
- 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.
- Please bring a copy of your programs Physical Demands Analysis to your health provider for his/her review - this is located on the St. Clair College website with your program requirements.

**Pre-Entrance Health Examination**

- Fill in name and birthdate at the top of page

**Health History by NP or Physician**

- 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 for all programs * ** (see exceptions)
- 2 doses MMR OR serology indicating immunity
- 2 doses Varicella OR serology indicating immunity
- Hep B vaccine series and proof of immunity
- 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
- Students please keep copies of your finished health forms for your own records. You will need this for employment purposes.
HEALTH HISTORY
(This page to be completed by STUDENT and reviewed by Dr or NP)

Name:_________________________________ Student I.D. #______________ Date of Birth:______________

Address:_____________________________ City/Prov/PC:__________________ Home Phone:______________

HealthCard#_________________________ 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:

<table>
<thead>
<tr>
<th>Condition</th>
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<tbody>
<tr>
<td>High blood pressure</td>
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<tr>
<td>Kidney disease</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Stroke</td>
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<td>Bleeding tendencies</td>
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<td>Tuberculosis</td>
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<td>Cancer</td>
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<td>Seizures</td>
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<td>Colitis</td>
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<td>Emphysema</td>
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<td>Heart disease</td>
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<td>Anemia</td>
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<td>Ulcers</td>
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<tr>
<td>Diabetes</td>
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<td>Other serious illness</td>
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<tr>
<td>Mental illness</td>
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<tr>
<td>Gout</td>
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<tr>
<td>Gout</td>
<td></td>
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</tbody>
</table>

Lifestyle

What is your sleep pattern?_______________________________________ Do you feel rested?___________________________

Appetite: Poor       Fair       Good       Do you eat from all food groups?_____________________________________________________

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? Y or N If yes, please list:____________________________________________

Are you currently taking any medications or supplements? Y or N please list:_____________________________________

Do you have any allergies? Y or N 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.

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:_________________________
**Immunization/Communicable Disease Record**

*(To be completed by PHYSICIAN or NURSE PRACTITIONER)*

<table>
<thead>
<tr>
<th>HEALTH SCIENCES PROGRAMS</th>
<th>COMMUNITY STUDIES or FOOD SERVICE PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(HEPATITIS B SERIES REQUIRED)</td>
<td>(HEP B SERIES HIGHLY RECOMMENDED BUT NOT REQUIRED)</td>
</tr>
</tbody>
</table>

**Hepatitis B Series**

<table>
<thead>
<tr>
<th>Date #1</th>
<th>Date #2</th>
<th>Date #3</th>
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</table>

**Hepatitis B Titre Indicating Immunity Or Completion of 1st 2 Doses 1 month apart or (3 doses if fast tracking)**

Required for all students in Health Sciences programs to be allowed into placement

**Hep B antibodies**

*Date tested:* ______________  
*Results:* ______________

*(To be tested 1-6 months after Hepatitis B series is completed)*

If 2 dose series given in grade school, check immunity- if immune no further doses needed; if not immune give booster dose and recheck serology 1 month later

Once serology shows immunity, it doesn’t have to be rechecked

If incomplete series, and not immune, give remainder of series and check serology 1 month after

If not immune after 1st series, another series of 3 doses is given with serology after 1 month- **IF NOT IMMUNE, PT NEEDS TO BE ADVISED OF NON IMMUNE STATUS**

**Measels, Mumps, Rubella Vaccine** *(2 doses)*

*Date: #1 ____________________ Date: #2 ___________________

If 2 doses received, serology not required

OR

If only 1 dose received, give second shot- no need to check immunity

Laboratory evidence of immunity : *Date: ____________________*

**Varicella vaccine** *(2doses)*

*Date: #1 ____________________ Date: #2 ___________________

6-8 weeks apart- don’t need serology after

OR

Laboratory evidence of Immunity: *Date:_______________________*

**Tetanus and Diptheria**

*Date:_______________________* (Must be repeated every 10 years)

**Pertussis**

*Date:_______________________* Give with Td in adolescence; 2nd dose in adulthood

**Polio**

*Date:_______________________* Last documented vaccine

**Influenza**

*Date:_______________________* (Yearly update)
**Pre-Entrance Health Examination**

(This page to be completed by PHYSICIAN or NURSE PRACTITIONER)

Name: ___________________________________________ Date of birth: _______________ Sex: M / F

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


<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal Findings</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Head/ Neck</td>
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<tr>
<td>Eyes/ Sclera/Pupils</td>
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<tr>
<td>Ears</td>
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<td>Nose/Mouth/Throat</td>
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<tr>
<td>Lymph Nodes</td>
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<td>Heart: Sounds/Rhythm</td>
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<td>Peripheral Vascular</td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Chest contour</td>
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<td>Skin</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Hernia: yes / no</td>
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<tr>
<td>Neck/Back/Spine:</td>
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<tr>
<td>Alignment / ROM</td>
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<td>Neuro-musculo-skeletal</td>
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<tr>
<td>Upper extremities</td>
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<td>Lower extremities</td>
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<tr>
<td>Reflexes</td>
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<tr>
<td>Balance + coordination</td>
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<tr>
<td>Posture</td>
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<tr>
<td>Psychosocial/Mental</td>
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</table>

**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? YES / NO

Person may participate in the following activities: At the following level:

______Walking _____Running _____Lifting _____Bending

______Light ______Moderate ______Strenuous ______

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

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

_____________________________________________________________________________________

If this person requires medical restrictions, please list restrictions:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

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

________________________________________________

Date & Signature of Physician or Nurse Practitioner Office Stamp
Immunization/Communicable Disease Record

(To be completed by PHYSICIAN or NURSE PRACTITIONER)

REQUIRED BY ALL PROGRAMS

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.

One step if 2-step > 1 yr ago- Date given:___________     +____mm / -____  Date Read:___________  Init:____

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: Age received:____________________
4. Public Health Unit Notified: Yes_____________ No___________________
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
Repeat chest x-rays not necessary unless clinically indicated; S&S noted above have been discussed
Should be assessed yearly by Health Care Provider in lieu of TB testing.