



Directions for Completing Medical Requirement Forms (2018)

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

<p>The student's acceptance into the clinical/field placement is conditional upon the completion of the enclosed forms.</p> <p style="text-align: center;">STUDENT RESPONSIBILITY</p> <p>You must closely follow these directions.</p> <p>Bring your immunization record to first visit</p> <p>Please call your local public health unit for your immunization record</p>	<p>Health History</p> <p><input type="checkbox"/> Complete the page, sign and date at bottom</p> <p>Immunization/Communicable Disease Record</p> <p><input type="checkbox"/> Complete top portion of both pages</p> <p><input type="checkbox"/> Provide proof of immunization history</p> <p><input type="checkbox"/> If you have had a negative TB skin test in the previous 12 months- proof of this must be provided.</p> <p><input type="checkbox"/> 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.</p> <p>Pre-Entrance Health Examination</p> <p><input type="checkbox"/> Fill in name and birthdate at the top of page</p>
<p style="text-align: center;">We recommend that you make appointment with Physician or Nurse Practitioner <u>as soon as you receive this form.</u></p>	<p style="text-align: center;">NOTE: This process may take 2 months to complete</p>
<p>PHYSICIAN / NURSE PRACTITIONER RESPONSIBILITY</p> <p>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.</p> <p>* TB skin testing is <i>not</i> required for students who have had a <i>previously positive TB skin test</i>. A chest x-ray will be required.</p> <p>** If there is a record of a previous <i>negative TB skin test in the past 12 months</i>, only one more TB skin test needs to be done <i>if documentation is provided</i>.</p>	<p>Health History by NP or Physician</p> <p><input type="checkbox"/> Review any problem areas with student</p> <p>Immunization/Communicable Disease Record</p> <p><input type="checkbox"/> Administer 2 TB skin tests (minimum 1 week apart) NOTE: A 2-step TB skin test is MANDATORY for all programs * ** (see exceptions)</p> <p><input type="checkbox"/> 2 doses MMR OR serology indicating immunity</p> <p><input type="checkbox"/> 2 doses Varicella OR serology indicating immunity</p> <p><input type="checkbox"/> Hep B vaccine series and proof of immunity</p> <p><input type="checkbox"/> Administer vaccines if needed</p> <p><input type="checkbox"/> Certify that student is free of symptoms of reportable communicable diseases (sign & date)</p> <p>Pre-Entrance Health Examination</p> <p><input type="checkbox"/> Record your findings</p> <p><input type="checkbox"/> Complete physical ability clearance section</p> <p><input type="checkbox"/> Include the office stamp with your name, address and phone number</p> <p><input type="checkbox"/> Sign and date at the bottom of the form</p> <p><input type="checkbox"/> Students please keep copies of your finished health forms for your own records. You will need this for employment purposes.</p>
<p>ST. CLAIR COLLEGE HEALTH CENTRE RESPONSIBILITY</p>	<p>PrePlacement Medical Clearance by HEALTH CENTRE STAFF</p> <p><input type="checkbox"/> Review records and validate that all requirements have been met according to Ontario Guidelines</p> <p><input type="checkbox"/> Issue a "Passport to Health" if all requirements are complete</p>



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:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Stroke	<input type="checkbox"/> Bleeding tendencies	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizures	<input type="checkbox"/> Colitis
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Anemia
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other serious illness (specify): _____
<input type="checkbox"/> Mental illness	<input type="checkbox"/> Gout	_____

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: _____

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: _____

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 yes / no			
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? **YES / NO**

Person may participate in the following activities:

_____ Walking _____ Running _____ Lifting _____ Bending

At the following level:

_____ 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



ST. CLAIR COLLEGE
OF APPLIED ARTS & TECHNOLOGY

NAME _____

PROGRAM _____ STUDENT # _____

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.**