Directions for Completing Medical Requirement Forms

Ontario regulations require a health screening program for persons entering certain clinical/field placement settings. Therefore, the student's acceptance into the program is conditional upon the completion of the enclosed forms. Please closely follow the directions listed below.

STUDENT RESPONSIBILITY	***PHYSICIAN / NURSE PRACTITIONER REPONSIBILITY***
Health History ☐ complete the page, sign and date at bottom	**Health History** ☐ review any problem areas with student
Immunization/Communicable Disease Record ☐ complete ***top*** portion of the page ☐ provide proof of immunization history	**Immunization/Communicable Disease Record** ☐ **administer 2 TB skin tests** (2nd test to be administered 1-3 weeks after first test in opposite arm). Note: If student has had a negative TB skin test in previous 12 months- proof of this must be provided, thus you only need to administer 1 TB skin test. ☐ draw blood for **MMR titre, Varicella titre. and Hepatitis B seroconversion** for all students as indicated ☐ administer vaccines if needed ☐ certify that student is free of symptoms of reportable communicable diseases
Pre-Entrance Health Examination ☐ fill in name and date of birth at the top of page	**Pre-Entrance Health Examination** ☐ record your findings ☐ complete physical ability clearance section ☐ include the office stamp with name, address and phone number ☐ sign and date the at the bottom of the form If you have any questions about the forms or the requirements, please contact the Campus Nurse at (519) 972-2380 (Windsor) or (519) 354-9100 ext. 3229 (Chatham).

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.

April 2009

ST. CLAIR COLLEGE
OF APPLIED ARTS & TECHNOLOGY

HEALTH HISTORY

(This page to be completed by STUDENT)

Name:____ Student I.D. #_____________ Date of Birth:______________

Address:______________________________ City/Prov/PC:_________________________ Home Phone:______________

HealthCard#__________________________________ Version Code:__________

Emergency Contact (Name/Relationship/Tel. #):____

Family History

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

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

Lifestyle

What is your sleep pattern?___________________________________ Do you feel rested?_________________________

Appetite: Poor Fair Good 24 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:_____________

Reproductive History (Female only)

Age when menstrual periods began__________________ Start date of last normal menstrual period_______________

Are your periods regular?_______ How often do they occur?_____________ How many days do they last?__________

Any problems with your periods? (if yes, please explain)____

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**:______________________

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 or nurse practitioner.

Immunization/Communicable Disease Record

(To be completed by PHYSICIAN or NURSE PRACTITIONER)

HEALTH SCIENCES PROGRAMS (REQUIRED)	**COMMUNITY STUDIES or FOOD SERVICE PROGRAMS (HIGHLY RECOMMENDED BUT NOT REQUIRED)**

Hepatitis B Series Date #1_________________ Date #2_________________ Date #3_______________

ALL PROGRAMS (REQUIRED)

2-step TB skin test * Date administered #1:_____________ + ___ mm / - ___ Date read:____________ Init.______

** Date administered #2: _____________ + ___ mm / - ___ Date read: ____________ Init.______

* TB skin testing is *not* required for students who have had *BCG vaccine or previously positive TB skin test.*
** 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.

Chest X-ray (required only if there is a recent positive TB reaction $\geq$ 10mm or if person has symptoms of active illness)

Date:____________ Results:____

Measles, Mumps Rubella Vaccination Date #1_______________ Date #2__________________

Varicella Vaccination or + History of Chicken Pox or Shingles Date ____________________

Hep B Seroconversion (required on all students) Date tested:_____________ Results:_______________
(To be tested no sooner than 8 weeks after Hepatitis B series is completed)

Measels, Mumps, Rubella Titer (required on all students) Date tested:_____________ Measles:_______________
(To be tested no sooner than 8 weeks after MMR vaccine is administered) Mumps:_____________ Rubella:________________

Varicella Titer (required on all students) Date tested:_____________ Results:_______________
(To be tested no sooner than 8 weeks after Varicella vaccine is administered)

It is recommended that the student have current immunization against the following:

Tetanus and Diptheria Date______________________ (Strongly recommend to be repeated every 10 years)

Pertussis Date______________________ (Strongly recommend to be repeated with Td up to age 24)

Polio Date______________________

Meningitis Date______________________ (Highly recommended for ages 19 or younger)

The above recommendations are based on Ontario Guidelines for Immunization. If you do not feel it is necessary or advisable at this time to administer one or any of the vaccines listed above, please note the reason(s) for this:

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

____ _________________________________

Signature of Physician or Nurse Practitioner **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			
Reproductive			
Hernia			
Neck/Back/Spine: Alignment / ROM			
Neuro-musculo-skeletal Upper extremities Lower extremities			
Reflexes			
Balance + coordination			
Posture			

PHYSICAL ABILITY CLEARANCE:

Paramedic and Nursing students must be able to perform two-person lifts/transfers of clients weighing up to 86kg (190 lbs).
Child and Youth Worker students must be physically fit enough to be certified in a restraint protocol for all age groups.
Early Childhood Education students will have to lift young children and move furniture and equipment.
Food Service students must be physically fit enough to carry trays of food weighing up to 30 kg (66 lbs).

In your opinion, is this individual capable of performing such lifts/transfers/restraints/or carries safely? Y / N

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

At the following level:
___Light ___Moderate ___Strenuous

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

If there are any other medical conditions of which the college should be aware (ex: epilepsy, diabetes, allergies, high/low blood pressure, pregnancy, musculo-skeletal injuries or physical defects, etc.), please give recommendations: ___________________

____

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 or Nurse Practitioner** ______________ **Date of Exam**