



## Directions for Completing Medical Requirement Forms (2012)

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

<p>The student's acceptance into the program is conditional upon the completion of the enclosed forms.</p> <p style="text-align: center;"><b>STUDENT RESPONSIBILITY</b></p> <p><b>You must closely follow these directions.</b></p> <p>No student will be allowed to go into a clinical placement without completing these requirements.</p>	<p><b><u>Health History</u></b></p> <p><input type="checkbox"/> Complete the page, sign and date at bottom</p> <p><b><u>Immunization/Communicable Disease Record</u></b></p> <p><input type="checkbox"/> Complete <b>top</b> portion of the page</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><b><u>Pre-Entrance Health Examination</u></b></p> <p><input type="checkbox"/> Fill in demographic information at the top of page</p>
<p><b><u>We recommend that you make appointment with Physician or Nurse Practitioner as soon as you receive this form.</u></b></p>	<p style="text-align: center;"><b>NOTE: This process may take 2 months to complete</b></p>
<p style="text-align: center;"><b>PHYSICIAN / NURSE PRACTITIONER RESPONSIBILITY</b></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. 3229.</p> <p>* TB skin testing is <i>not</i> required for students who have had <i>BCG vaccine or previously positive TB skin test.</i></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.</p>	<p><b><u>Health History</u></b></p> <p><input type="checkbox"/> Review any problem areas with student</p> <p><b><u>Immunization/Communicable Disease Record</u></b></p> <p><input type="checkbox"/> Administer <b>2</b> TB skin tests ( minimum 1 week apart) <b>NOTE: A 2-step TB skin test is <u>MANDATORY</u> * **</b></p> <p><input type="checkbox"/> Test for Measles, Mumps, Rubella, and Varicella titres and for Hepatitis B antibodies <b><u>MANDATORY</u></b></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 &amp; date)</p> <p><b><u>Pre-Entrance Health Examination</u></b></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 style="text-align: center;"><b>ST. CLAIR COLLEGE HEALTH CENTRE RESPONSIBILITY</b></p>	<p><b><u>Passport to Health</u></b></p> <p><input type="checkbox"/> Review records and validate that all requirements have been met according to SCC policy.</p> <p><input type="checkbox"/> Issue a "Passport" if all requirements are complete</p>

*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. **January 2012***



# 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 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) (For Dr or NP to assess and make recommendations if needed)

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: \_\_\_\_\_



**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)
<b>Hepatitis B Series</b> Date #1 _____    Date #2 _____    Date #3 _____	
<b>ALL PROGRAMS (REQUIRED)</b>	
<b>2-step TB skin test *</b> Date administered #1: _____ + ___ mm / - ___    Date read: _____    Init. _____ **    Date administered #2: _____ + ___ mm / - ___    Date read: _____    Init. _____	
<small>* TB skin testing is <u>not</u> required for students who have had <i>BCG vaccine or previously positive TB skin test.</i>            ** 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.</small>	
<b>Chest X-ray</b> (required only if there is a recent positive TB reaction $\geq$ 10mm or if person has symptoms of active illness) Date: _____    Results: _____	
<b>Measles, Mumps Rubella Vaccination</b> Date #1 _____    Date #2 _____	
<b>Varicella Vaccination or positive History of Chicken Pox or Shingles</b> Date _____	
<b>Hep B Seroconversion (required on all students)</b> Date tested: _____    Results: _____ <small>(To be tested no sooner than 8 weeks after Hepatitis B series is completed)</small>	
<b>Measels, Mumps, Rubella Titer (required on all students)</b> Date tested: _____    Measles: _____ <small>(To be tested no sooner than 8 weeks after MMR vaccine is administered)</small> Mumps: _____    Rubella: _____	
<b>Varicella Titer (required on all students)</b> Date tested: _____    Results: _____ <small>(To be tested no sooner than 8 weeks after Varicella vaccine is administered)</small>	
It is recommended that the student have current immunization against the following:	
<b>Tetanus and Diptheria</b>	Date _____ (Strongly recommend to be repeated every 10 years)
<b>Pertussis</b>	Date _____ (Give with Td up to age 64 if not previously done as adult)
<b>Polio</b>	Date _____
<b>Meningitis</b>	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:	
<b>I certify that as of this date, the student is free of any symptoms of active illness of any reportable communicable diseases.</b>	
_____ <b>Signature of Physician or Nurse Practitioner</b>	_____ <b>Date</b>



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:**

Person may participate in the following:

At the following level:

- |   |                                 |                                   |  |
|---|---------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Walking/Standing                       | <input type="checkbox"/> Light  | <input type="checkbox"/> Moderate | <input type="checkbox"/> Strenuous   |
| <input type="checkbox"/> Running                                | <input type="checkbox"/> Light  | <input type="checkbox"/> Moderate | <input type="checkbox"/> Strenuous   |
| <input type="checkbox"/> Bending                                | <input type="checkbox"/> Light  | <input type="checkbox"/> Moderate | <input type="checkbox"/> Strenuous   |
| <input type="checkbox"/> Pushing/Pulling                        | <input type="checkbox"/> 20 lbs | <input type="checkbox"/> 50 lbs   | <input type="checkbox"/> 100 lbs <input type="checkbox"/> 210 lbs                                  |
| <input type="checkbox"/> Lifting                                | <input type="checkbox"/> 50 lbs | <input type="checkbox"/> 100 lbs  | <input type="checkbox"/> 120 lbs <input type="checkbox"/> 210 lbs                                  |
| <input type="checkbox"/> Physically restrain aggressive persons | <input type="checkbox"/> 50 lbs | <input type="checkbox"/> 100 lbs  | <input type="checkbox"/> 120 lbs <input type="checkbox"/> 210 lbs                                  |
| <input type="checkbox"/> Carrying                               | <input type="checkbox"/> 20 lbs | <input type="checkbox"/> 50 lbs   | <input type="checkbox"/> 100 lbs <input type="checkbox"/> 120 lbs <input type="checkbox"/> 210 lbs |

Are there 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 deficits)? If so, 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