DIRECTIONS FOR COMPLETING MEDICAL REQUIREMENT FORMS (2019)

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

THIS PROCESS MAY TAKE 2 MONTHS TO COMPLETE
BOOK APPOINTMENT WITH PHYSICIAN OR NURSE PRACTITIONER AS SOON AS YOU RECEIVE THIS FORM

STUDENT RESPONSIBILITY: Note that you MUST bring your immunization record to each visit with physician and Health Centre – Please go online or call your local Public Health unit to obtain record

TO BE COMPLETED BY STUDENT:

☐ Complete the Health History Form, sign and date at the bottom
☐ Obtain immunization record for appointment with physician or nurse practitioner and bring original and 1 copy to appointment at Health Centre
☐ Obtain original and 1 COPY of entire Medical Requirement Form including serology reports for appointment with Health Centre * Note the Health Centre WILL NOT make copies for you *
☐ 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

TO BE COMPLETED BY PHYSICIAN or NURSE PRACTITIONER:

Immunization/Communicable Disease Record

☐ Hep B vaccine serology reports (If no immunity MUST have Hep B series and serology after 1 month of series)
☐ 2 doses MMR OR serology indicating immunity, if not immune to Rubella only 1 dose of MMR needed
☐ 2 doses Varicella OR serology indicating immunity
☐ 2-step TB skin tests; MANDATORY for all programs (minimum 1 week apart from initial administration of 1st TB skin test)
  * Not required for students with positive TB skin test – a chest x-ray will be required
  * If there is a record of previous negative TB skin test in past 12 months, only one more test needs to be done if documentation provided

Pre-Entrance Health Examination – MUST BE FILLED OUT COMPLETELY; ANY UNCOMPLETED SECTIONS WILL NOT BE ACCEPTED BY HEALTH CENTRE

☐ Each system must be recorded as normal or abnormal. This will ensure students safety, as well as safety of clients. Please DO NOT skip this section. Please sign and date.

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. 3729.
Immunization/Communicable Disease Record
(To be completed by Physician or Nurse Practitioner)
*REQUIRED FOR ALL PROGRAMS*

Initial 2-Step TB Test – Mandatory (2nd step to be administered minimum 7 days after 1st step given)
ALL TB SKIN TESTS TO BE READ 48-72 HOURS AFTER ADMINISTRATION
2nd TB skin test must be done no more than 12 months after 1st step

TB Skin Test #1
Date administered: __________ +_____ mm / -_____ Date read: __________ Initial: ______

TB Skin Test #2
Date administered: __________ +_____ mm / -_____ Date read: __________ Initial: ______

* If there is a record of a previous NEGATIVE 2-step TB skin test, must provide documentation and only one more TB skin test needs to be done.
* If there is a record of a previous POSITIVE TB skin test, a chest x-ray must be done.

IF EITHER STEP IS POSITIVE (10mm or more), PLEASE EVALUATE THE FOLLOWING:

1. Chest x-ray results: Date: __________ Positive □ Negative □
2. History of disease: Yes □ No □
3. Public Health Unit Notified: Yes □ No □
4. INH prophylaxis: Yes □ No □ Dosage: _______ Duration:_________
5. Dose 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 □
Immunization/Communicable Disease Record
(To be completed by Physician or Nurse Practitioner)

*REQUIRED FOR ALL STUDENTS IN HEALTH SCIENCES PROGRAMS TO BE ALLOWED INTO PLACEMENT*

Hepatitis B titre indicating immunity OR completion of first 2 doses 1 month apart

Hepatitis B Series

<table>
<thead>
<tr>
<th>Date #1</th>
<th>Date #2</th>
<th>Date #3</th>
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If 2 dose series given in grade school, or if immunity status is unknown, check immunity – if immune, no further doses needed; if not immune give booster dose and recheck serology 1 month later.
If not immune after 1st series, another series of 3 doses is given with serology 1-6 months after – IF NOT IMMUNE, CLIENT NEEDS TO BE ADVISED OF NON-IMMUNE STATUS

Hepatitis B Antibodies

Results: ______________________ (ATTACH BLOODWORK)
(To be tested 1-6 months after Hepatitis B series is completed)

_____________________________________________________________________________________

MMR AND VARICELLA:
If 2 doses received, serology NOT required.
If only 1 dose received, must give 2nd shot – no need to check immunity.

Measles, Mumps, Rubella (2 doses, at least 4 weeks apart)

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<thead>
<tr>
<th>Date #1</th>
<th>Date #2</th>
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OR

Proof of MMR immunity: Results: ______________________ (ATTACH BLOODWORK)

_____________________________________________________________________________________

Varicella (2 doses, at least 6 weeks apart): Date #1: ________ Date #2: ________

OR

Proof of Varicella immunity: Results: ______________________ (ATTACH BLOODWORK)

_____________________________________________________________________________________

TDP

Date: ___________________ (must be repeated every 10 years)
(Need 1 dose of Pertussis age >= 19 years of age)

Polio

Date: _________________ Last documented vaccine
HEALTH HISTORY
(To be completed by STUDENT and reviewed by Physician or Nurse Practitioner)

Name: ____________________________________________________  Date of Birth: _______________
(First name)                    (Middle Initial)                          (Last name)
Student ID #:________________   Phone Number: _____________  Email: ________________________
Address:_____________________________  City/Prov: __________________ Postal Code: __________
Health Card #: ________________________ VC: ______  Emergency Contact: _____________________
Relationship: __________________ Emergency Contact Phone Number: __________________________

Family History
Please check if any RELATIVE (parents, grandparents, siblings, or children) has had any of the following conditions:

□ High Blood Pressure  □ Kidney Disease  □ Asthma  □ Gout
□ Stroke  □ Bleeding Tendencies  □ Tuberculosis  □ Mental Illness
□ Cancer  □ Seizures  □ Colitis  Other Serious Illness
□ Emphysema  □ Heart Disease  □ Anemia  (Specify): ______________
□ Ulcers  □ Diabetes

Lifestyle
How many hours do you sleep on average per night? __________  Do you feel rested? ______________
Appetite: Poor □ Fair □ Good □ Are there food groups you do not eat? _________________________
Do you:
Y or N  Smoke       Packs per day: _______       Age started smoking: ________
Y or N  Drink alcohol       Drinks per day/week: _____________________________
Y or N  Drink /eat caffeine       Amount per day: ________________
Y or N  Use recreational drugs       Frequency: _________________
Y or N  Exercise       Type: ______________       Frequency: ______________

Current Health Status
Do you currently have any health problems? Y or N  Please list: _________________________________
Are you currently taking any medications or supplements? Y or N  Please list: __________________
Do you have any allergies? Y or N  Please list: __________________

Personal Illness/Injury History
Childhood illness, adult illnesses, medical conditions, and surgeries: Y or N  Please List:
________________________________________________________________

Previous accidents or injuries that you have had: Y or N  Please list:
________________________________________________________________

- 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 my 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)

<table>
<thead>
<tr>
<th>Name: ________________________________</th>
<th>Date of birth: ____________________</th>
<th>Sex: M / F</th>
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<tbody>
<tr>
<td>Height: _______  Weight: _______  Blood Pressure: <em><strong><strong><strong>/</strong></strong></strong></em></td>
<td>Temp: _______  Pulse: _______  Resp: _______</td>
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<tr>
<td>Vision: R 20/____ L 20/____  Corrected: Y / N  Contacts: Y / N  Glasses Y / N  Hearing: R_______ L ________</td>
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<thead>
<tr>
<th>Normal</th>
<th>Abnormal Findings</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Head/ Neck</td>
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<td>Eyes/ Sclera/Pupils</td>
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<td>Ears</td>
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<td>Nose/Mouth/Throat</td>
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<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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<td>Lungs</td>
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<td>Chest contour</td>
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<td>Skin</td>
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<td>Abdomen</td>
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<td>Hernia: yes / no</td>
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<td>Neck/Back/Spine:</td>
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<td>Alignment / ROM</td>
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<td>Neuro-musculo-skeletal</td>
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<td>Upper extremities</td>
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<td>Lower extremities</td>
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<td>Reflexes</td>
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<td>Balance + coordination</td>
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<td>Posture</td>
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<tr>
<td>Psychosocial/Mental</td>
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**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