St. Clair College Health Services

DIRECTIONS FOR COMPLETING MEDICAL REQUIREMENT FORMS 2020/2021

In accordance with the current Ontario Hospital Association Communicable Diseases Surveillance Protocols and the Canadian Immunization Guide, students in programs with field placements where there is contact with vulnerable individuals, must complete a medical evaluation.

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

TO BE COMPLETED BY STUDENT:

Page 1 Student Health History

□ Complete the Health History Form, sign and date at the bottom

STUDENT RESPONSIBILITY: (Prior to your appointment with a Physician or Nurse Practitioner)

□ You MUST bring your immunization record with you to your appointment and make a copy for your physician/nurse practitioner to attach to your forms. Please go online or call your local Public Health unit to obtain record if you do not have a current copy.

□ Please bring a copy of your Program's Physical Demands (PPD) 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:

Page 2 Immunization/Communicable Disease Record

□ Must be signed and dated

□ Must attach Lab reports for Hep BsAb only if student is in a health science program

□ Must attach Lab reports for Varicella & MMR titres if there are not 2 documented doses of the vaccines

Page 3 Physical Examination

□ Must be completed in accordance with the student's Program Physical Demands (PPD) by MD or NP recommendations regarding student's ability to meet requirements of PPD.

Page 4 Medical Clearance Form

□ Must complete recommendations regarding student's ability to meet requirements of PPD

□ Must be signed and dated

□ Must include Office Stamp with name and contact information of health practitioner

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

TO BE COMPLETED BY ST. CLAIR COLLEGE HEALTH CENTRE NURSE:

Page 4 Passport to Health

□ Must be signed and dated

□ Give copy to student when complete

If you have any questions about the forms or the requirements, please contact the St. Clair College Health Centre Campus Nurse at 519-972-2380 (Windsor) or (Chatham).

STUDENT HEALTH HISTORY

(To be completed by STUDENT and reviewed by Physician or Nurse Practitioner)

Name: _____ Date of Birth: _____
(First name) (Middle Initial) (Last name) (MM/DD/YY)

Student ID #:_____ Program:_____ Phone Number: _____

Address:_____ City/Prov: _____ Postal Code: _____

Health Card #: _____ VC: _____ Email address:_____

Emergency Contact/Relationship/Tel. #: _____

Have you printed off and attached a copy of your Program Physical Demands Analysis? NO or YES

Have you read and do you understand what your program requires of you on your Program Physical Demands Analysis? NO or YES

Current Health Status

Do you currently have any health problems? NO or YES- If YES, please list:_____

_____

Are you currently taking any medications or supplements that affect your ability to perform or meet the physical demands of your program? NO or YES - If YES, please list:

_____

Do you have any allergies? NO or YES - If YES, please list: _____

Do you have a history of any personal illness or medical condition that could affect your ability to perform or meet the physical demands of your program? NO or YES If YES, please list:

_____

Do you have a history of any personal injury that could affect your ability to perform or meet the physical demands of your program? NO or YES - If YES, 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: _____

Name: _____ Date of Birth:_____
(First name) (Middle Initial) (Last name) (MM/DD/YY)

Program: _____ Student ID Number:_____

Immunization/Communicable Disease Record

(To be completed by Physician or Nurse Practitioner)

For Health Science Programs Only:

Hepatitis B Series Date #1: _____ Date #2: _____ Date #3: _____

-Required 2 doses given at least one month apart, and a booster dose at least 5 months after 2nd dose.
-Serology may be repeated no sooner than one month after vaccinations to determine immune response. -If not immune after 1st series, another series of 3 doses may be required.
-Check immunity (all students).

Must attach lab reports for Hepatitis BsAb **Immune Response: YES □ NO □**

Influenza Date of most recent Influenza Vaccine_____

For All Programs:

Measles, Mumps, Rubella Date #1: _____ Date #2: _____

- If 2 doses received, serology NOT required.
- If only 1 dose given, give 2nd dose no sooner than 1 month after 1st dose –no need to check immunity.
- If no record of vaccination, must have proof of immunity for Measles, Mumps, Rubella, Attach Serology for MMR (if required) **Immune Response: YES □ NO □**

Varicella Date #1: _____ Date #2: _____

- If 2 doses received, serology NOT required.
- If only 1 dose given, give 2nd dose no sooner than 1 month after 1st dose –no need to check immunity.
- If no record of vaccination, must have proof of Varicella immunity Varicella Attach Serology for Varicella (if required) **Immune Response: YES □ NO □**

TDaP Date: _____ must be up-to-date within 10 years. If no record of TDaP at 19 yrs of age or older, must have booster even if last Td is within 10 years to ensure immunity to Pertussis.

Tuberculosis Screen

If there is a history of a POSITIVE TB skin test (TBST), a **chest x-ray** must be done instead of TBST. If this is initial testing, a 2-step TBST is mandatory (2nd step to be administered no sooner than 7 days and no longer than 12 months after 1st TBST is given). If there is a documented record of a NEGATIVE TB skin test in the previous 12 months, student will only need a one-step TB skin currently.

TB Skin Test #1
Date administered: _____ +_____mm / -_____ Date read: _____ Initial: _____

TB Skin Test #2
Date administered: _____ +_____mm / -_____ Date read: _____ Initial: _____

NOTE: TBST MUST BE READ 48-72 HOURS AFTER ADMINISTRATION to be valid
A POSITIVE TBST of 10mm or more requires Chest Xray (CXR) to r/o active TB.

CXR Date: _____ RESULTS: □ Negative / □ Positive for active TB

I certify that at this time, this person is free of signs and symptoms of active TB or other communicable illnesses.

Signature of MD or NP_____! Date:_____

PHYSICAL EXAMINATION

Name: _____ Date of Birth:_____

Program: _____ Student ID Number:_____

Physical examination to be completed by Physician or Nurse Practitioner in accordance with the student's Program Physical Demands (PPD) form

SYSTEM	FINDINGS
VITAL SIGNS	T: P: R: B/P: WT: HT: BMI:
NEUROLOGICAL	REFLEXES: GAIT: BALANCE: HISTORY OF SEIZURE Y / N HISTORY OF FAINTING Y / N
VISUAL	RT EYE __/20 LEFT EYE __/20 BOTH EYES __/20 GLASSES Y / N CONTACTS Y / N PERIPHERAL VISION RT: LT:
HEARING	RT EAR: LEFT EAR:
MUSCULOSKELETAL	UPPER BODY RT: LT: LOWER BODY RT: LT: SPINE:
CIRCULATORY	HEART SOUNDS & RHYTHM: PVS:
ABDOMINAL	HERNIA Y / N
PSYCHOSOCIAL	CONCERNS:

MEDICAL CLEARANCE FORM

Name: _____ Date of Birth:_____

Program: _____ Student ID Number:_____

Program Physical Demands Analysis (PPD)

Is the applicant able to meet the requirements of the attached PPD for his/her program? Check appropriate recommendation:

☐ Able to meet all physical demands without restriction

☐ Able to meet all physical demands with following restrictions:

_____

☐ May be able to meet all physical demands with the following special accommodations:

_____

☐ Is NOT able to meet all physical demands of desired program due to:

_____

MD/NP Office Stamp (Required)	_____ Date _____ Signature of MD or NP

Passport to Health: For St. Clair College Health Centre Use Only

Communicable Illness Assessment

This student is deemed free of signs & symptoms of communicable illness and has demonstrated adequate immunity and/or has completed required vaccinations.

☐ MMR
☐ Varicella
☐ Hepatitis B
☐ Tetanus/Diphtheria/Pertussis
☐ TB skin test (2-step or annual) or CXR ☐ Next annual TB screen or TBST due_____
☐ Date of most recent Influenza Vaccine_____

College Stamp Required for Validation	Date Completed_____ _____ Signature of SCCHC Nurse