Directions for Completing Medical Requirement Forms (2020)

Ontario Public Health 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.

The student's acceptance into the clinical/field placement is conditional upon the completion of the enclosed forms. ***STUDENT RESPONSIBILITY*** **You must closely follow these directions.**	**Health History** ☐ Complete the page, sign and date at bottom **Immunization/Communicable Disease Record** ☐ Complete ***top*** portion of both pages ☐ Provide proof of immunization history ☐ If you have had a negative TB skin test in the previous 12 months- **proof of this must be provided**. ☐ ***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.*** **Pre-Entrance Health Examination** ☐ Fill in name and birthdate at the top of page ☐ Print off and attach the Program Physical Demands Analysis and bring with this form to your Health Care Practitioner
We recommend that you make appointment with Physician or Nurse Practitioner as soon as you receive this form.	**NOTE: This process may take 2 months to complete**
PHYSICIAN / NURSE PRACTITIONER RESPONSIBILITY 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. * TB skin testing is *not* required for students who have had a ***previously positive TB skin test***. A chest x-ray will be required. ** 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 ***if documentation is provided***.	**Health History** ☐ Review any problem areas with student **Immunization/Communicable Disease Record** ☐ Administer **2** TB skin tests (minimum 1 week apart) **NOTE: A 2-step TB skin test is MANDATORY** for all programs * ** **(see exceptions)** . ☐ Test for Measles, Mumps,Rubella, and Varicella titres and for Hepatitis B antibodies **MANDATORY** . ☐ Administer vaccines if needed . ☐ Certify that student is free of symptoms of reportable communicable diseases (sign & date) **Pre-Entrance Health Examination** ☐ Record your findings ☐ Complete physical ability clearance section ☐ Include the office stamp with your name, address and phone number ☐ Sign and date at the bottom of the form
ST. CLAIR COLLEGE HEALTH CENTRE RESPONSIBILITY	**PrePlacement Medical Clearance** ☐ Review records and validate that all requirements have been met according to SCC policy. ☐ Issue a "**PrePlacement Medical Clearance**" if all requirements are complete

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:

____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 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? If yes, please list:_____

Are you currently taking **any medications or supplements**? 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 (HEPATITIS B SERIES REQUIRED)	**COMMUNITY STUDIES or FOOD SERVICE PROGRAMS (HEP B SERIES HIGHLY RECOMMENDED BUT NOT REQUIRED)**

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

REQUIRED FOR ALL STUDENTS
PLEASE DO ALL TITRES REQUESTED

NOTE: Please attach laboratory evidence of immunity

Hep B antibodies **Date tested**:_____ **Results**:_____
(To be tested no sooner than 8 weeks after Hepatitis B series is completed)

Measels, Mumps, Rubella vaccine **Date #1 _____** **Date #2 _____**

Varicella vaccine **Date_____**

Proof of Immunity: **Date tested**:_____
(To be tested no sooner than 8 weeks after MMR vaccine is administered)

Measles_____ **Mumps_____**
Rubella:_____ **Varicella_____**

Tetanus and Diptheria **Date_____** **(Must be repeated every 10 years)**

Pertussis **Date_____** **Give with Td up to age 64 if not previously done as adult)**

Polio **Date_____** **Last documented vaccine**

Influenza **Date_____** **(Yearly update)**

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			
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:_____

_____

_____

_____ _____

Date & Signature of Physician or Nurse Practitioner Office Stamp

ST. CLAIR COLLEGE

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.**

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: Date_____**
4. **Public Health Unit referral; Yes_____ No_____ Specialist referral_____**
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 •**

Signature of Physician or Nurse Practitioner_____ Date:_____