ST. CLAIR COLLEGE
OF APPLIED ARTS & TECHNOLOGY

Directions for Completing Medical Requirement Forms (2017)

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

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.

Bring your immunization record to first visit

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

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***.

Please retain copies of your finished health forms for your own records

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)** .
☐ 2 doses MMR **OR** serology indicating immunity
☐ 2 doses Varicella **OR** serology indicating immunity
☐ Hep B vaccine series and proof of immunity .
☐ 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 Ontario Guidelines
☐ Issue a "Passport to Health" if all requirements are complete

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

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? **Y or N** If yes, please list:_____

Are you currently taking **any medications or supplements**? **Y or N** please list:_____

Do you have any allergies? **Y or N** 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.**
- **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**:_____

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Program:_____ Student I.D. #_____

Name:_____
(Surname) (First name) (Middle initial)

NOTE TO STUDENT: For your first visit: Please bring your immunization card with you or call your Health Unit to get a copy

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_____

Hepatitis B Titre Indicating Immunity Or Completion of 1st 2 Doses in Series Required for Health Sciences Programs to be allowed into placement

Hep B antibodies **Date tested**:_____ **Results**:_____
(To be tested 1-6 months after Hepatitis B series is completed)
If 2 dose series given in grade school, check immunity- if immune no further doses needed; if not immune give booster dose and recheck serology 1 month later
Once serology shows immunity, it doesn't have to be rechecked
If incomplete series, and not immune, give remainder of series and check serology 1 month after
If not immune after 1st series, another series of 3 doses is given with serology after 1 month- **IF NOT IMMUNE, PT NEEDS TO BE ADVISED OF NON IMMUNE STATUS**

Measels, Mumps, Rubella Vaccine (2 doses) **Date: #1 _____** **Date #2 _____**

If 2 doses received, serology not required **OR**

If only 1 dose received, give second shot- no need to check immunity **Laboratory evidence of immunity : Date: _____**

Varicella vaccine (2doses) **Date: #1_____** **Date: #2_____**

6-8 weeks apart- don't need serology **OR**
after

Laboratory evidence of Immunity: Date: _____

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

Pertussis **Date_____ Give with Td in adolescence; 2nd dose in in adulthood**

Polio **Date_____ Last documented vaccine**

Influenza **Date_____ (Yearly update)**

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:_____

_____

_____

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**

ST. CLAIR COLLEGE
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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.**

One step if 2-step > 1 yr ago- Date given:_____ +____mm / -____ Date Read:_____ Init:____

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: Age received: _____**
4. **Public Health Unit Notified: Yes_____ No_____**
5. **INH prophylaxis: Yes_____ No_____ Dosage:_____ Duration_____**
6. **Does this student have signs and symptoms of active TB on physical exam:**

o **Fatigue.....**	**YES**	**NO**
o **Fever.....**	**YES**	**NO**
o **Night sweats.....**	**YES**	**NO**
o **Weight loss.....**	**YES**	**NO**
o **Coughing.....**	**YES**	**NO**
o **Blood tinged sputum..**	**YES**	**NO**
o **Hoarseness .....**	**YES**	**NO**
o **Chest pain.....**	**YES**	**NO**

Repeat chest x-rays not necessary unless clinically indicated; S&S noted above have been discussed Should be assessed yearly by Health Care Provider in lieu of TB testing.