ST. CLAIR COLLEGE

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.

ST. CLAIR COLLEGE

Program:_____ Student ID #:_____

Name: _____
(First name) (Middle Initial) (Last name)

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 ☐

ST. CLAIR COLLEGE

Program:_____ Student ID #:_____

Name: _____
(First name) (Middle Initial) (Last name)

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 **Date #1: _____ Date #2: _____ Date #3: _____**

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)

Date #1: _____ Date #2: _____

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)

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**