Professional Practice Health Form
School of Health Sciences – Year 1

Student Information

Name: _____ **Student ID:** _____

Email: _____ **Phone Number:** _____

Program Name: _____ **Year:** _____

IMPORTANT: A copy of your immunization and any lab results must be submitted to Synergy for clearance.

Section A: To be completed by Health Care Provider

Health Care Provider Signature and Office Stamp

Name: _____

Signature: _____

Date (dd/mm/yy): _____

OFFICE STAMP

Tuberculosis: The student must provide proof of a two-step Tuberculosis Mantoux skin test. If there is record of a two-step TB skin test in the past, dates and results must be recorded and followed up with a one-step TB skin test (if more than 12 months have passed). Documentation of the tuberculosis skin test is required regardless of receiving the BCG vaccine. Students with a positive skin test (10mm or more in duration) must have a chest x-ray.

Two Step Tuberculosis Skin Test

Step 1: Date Given (dd/mm/yy): _____

Date Read (dd/mm/yy): _____ **Result:** _____ **mm**

Step 2: Date Given (dd/mm/yy): _____

Date Read (dd/mm/yy): _____ **Result:** _____ **mm**

One Step Tuberculosis Skin Test

Step 1: Date Given (dd/mm/yy): _____

Date Read (dd/mm/yy): _____ **Result:** _____ **mm**

Students with a positive skin test (10mm or more in duration) must have a chest x-ray. ***A copy of the chest x-ray must be attached.***

Date of x-ray (dd/mm/yy): _____ **Results:** _____

Section A: To be completed by Health Care Provider

Mumps, Measles, Rubella (MMR): Proof of immunity to Mumps, Measles and Rubella or documented proof of the 2 dose series is required. If no immunity, the student must provide proof that they have received 2 doses of the MMR vaccine.

1. **Immunity to MMR:** Evidence of immunity to Mumps, Measles and Rubella. **A copy of the lab report must be attached.**

   Date blood work completed (dd/mm/yy):_____
   Mumps Immunity: ☐ Yes ☐ No **Measles Immunity:** ☐ Yes ☐ No **Rubella Immunity:** ☐ Yes ☐ No

2. **MMR Vaccine:** If no immunity, proof of 2 doses of MMR is required. **A copy of the immunization record must be attached.**
   MMR Dose 1 (dd/mm/yy):_____ **MMR Dose 2 (dd/mm/yy):** _____

Varicella: Proof of immunity to Varicella or documented proof of the 2 dose series is required. If no immunity, the student must provide proof that they have received 2 doses of the Varicella vaccine.

1. **Immunity to Varicella:** Evidence of immunity to Varicella. **A copy of the lab report must be attached.**
   Date blood work completed (dd/mm/yy):_____
   Varicella Immunity: ☐ Yes ☐ No

2. **Varicella Vaccine:** If no immunity, proof of 2 doses of Varicella is required. **A copy of the immunization record must be attached.**
   Varicella Dose 1 (dd/mm/yy):_____**Varicella Dose 2 (dd/mm/yy):**_____

Tetanus/Diphtheria (Td) and Polio: Completion of the initial series is required with a booster if more than 10 years. If the student has not completed the initial series, 2 doses is required. **A copy of the immunization record must be attached.**

1. **Tetanus/Diphtheria/Polio series completed (dd/mm/yy):**_____
   Booster completed (dd/mm/yy):_____

2. **Tetanus/Diphtheria Dose 1 (dd/mm/yy):**_____
   Tetanus/Diphtheria Dose 2 (dd/mm/yy):_____

3. **Polio Dose 1 (dd/mm/yy):**_____
   Polio Dose 2 (dd/mm/yy):_____

Section A: To be completed by Health Care Provider

Pertussis: Students are required to provide documentation of the Pertussis vaccine. If the student has not had the Pertussis vaccine they require Adacel or equivalent (if over the age of 18) Students under 18 should receive the initial series. **A copy of the immunization record must be attached.**

1. **Pertussis series complete (dd/mm/yy):**_____
2. **Dose of Adacel or equivalent (dd/mm/yy):**_____
3. **If under 18 with no history of an initial series, please provide 2 doses**
   Pertussis Dose 1 (dd/mm/yy):_____**Pertussis Dose 2 (dd/mm/yy):**_____

Hepatitis B: Proof of immunity to Hepatitis B is required. If no immunity, the student must show proof of 2 doses (minimum).

1. **Immunity to Hepatitis B:** Evidence of immunity to Hepatitis B. **A copy of the lab report must be attached.**
   Date blood work completed (dd/mm/yy):_____
   Hepatitis B Immunity: ☐ Yes ☐ No

2. **Hepatitis B Vaccine:** If no immunity, proof of 2 doses (minimum) of Hepatitis B is required. **A copy of the immunization record must be attached.**
   Hepatitis B Dose 1 (dd/mm/yy):_____ **Hepatitis B Dose 2 (dd/mm/yy):** _____
   Hepatitis B Dose 3 (dd/mm/yy):_____ **Hepatitis B Booster (dd/mm/yy):** _____

Influenza: An annual seasonal flu shot is not mandatory but highly recommended. Any student without the vaccination may be in jeopardy of a successful completion of the clinical course in the event of an outbreak at your placement. The influenza vaccine is available from October to March. **Documentation of the influenza vaccine clearly indicating the date received must be attached.**

Influenza Vaccine Received (dd/mm/yy):_____

COVID-19 Vaccine: This vaccine is mandatory. **Documentation of the COVID-19 vaccine clearly indicating the date received must be attached**

Dose 1 received (dd/mm/yy):

Dose 2 received (dd/mm/yy):_____

_____

Section B: To be completed by the student

Non Medical Requirements: The following non medical requirements must be completed. If you have previously obtained one or more of these requirements, please verify the expiry date. If your certificate expires during the placement portion for your program, it is your responsibility to recertify within one month from the time of expiration. **A copy of all non medical documents/certificates must be attached.**

CPR – BLS Certificate (annual recertification)
Valid Certificate: ☐ Yes ☐ No **Certificate Attached:** ☐ Yes ☐ No

Standard First Aid Certificate (every 3 years):
Valid Certificate: ☐ Yes ☐ No **Certificate Attached:** ☐ Yes ☐ No

Mask Fit Testing (every 2 years):
Valid Certificate: ☐ Yes ☐ No **Certificate Attached:** ☐ Yes ☐ No

Vulnerable Sector Police Check (annual):
Valid Certificate: ☐ Yes ☐ No **Certificate Attached:** ☐ Yes ☐ No

Student Signature: _____

Student Agreement:
I confirm that I have read this form and understand its purpose and the nature of its content. In particular, I understand that in order to comply with the Public Hospitals' Act and Ontario Hospital Association protocol, I need to demonstrate that certain health standards have been met in order for me to be granted student placement. I understand that the faculty in my educational program will be able to view the results from this form. I understand that I must have all sections of this form fully completed and reviewed by the identified due date. Failing to do so, may jeopardize my consideration for any student placement. All costs incurred for completion of this form are my sole responsibility. Should it be requested, it is my responsibility to share relevant information from this form with a hospital, nursing home, or other clinical placement agency relating to my program.

The personal information on this form is collected under the legal authority of the Colleges and Universities Act, R.S.O. 1980, Chapter 272, Section 5, R.R.O. 1990, Regulation 77 and the Public Hospital Act R.S.O. 1980 Chapter 410, R.S.O. 1986, Regulations 65 to 71 and in accordance with the requirements of the legal Agreement between the College and the agencies which provide clinical experience for students. The information is used to ensure the safety and well-being of students and clients in their care. The information in this form will be protected in accordance to the Freedom of Information and Protection of Individual Privacy Act.

Student Name: _____ **Student ID:** _____

Student Signature: _____ **Date (dd/mm/yy):** _____