Professional Practice Health Form
School of Nursing – Year 1

Name: _____ **Student ID:** _____

Program Name: _____

IMPORTANT: In addition to the completed health form, a copy of your immunization record(s) and any serology must be uploaded to Synergy for clearance. Bloodwork will be accepted if done within 10 years of having this form completed.

Section A: To be completed by Healthcare Provider

Healthcare Provider Signature

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 uploaded to Synergy.***

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

Section A: To be completed by Healthcare Provider

Mumps, Measles, Rubella (MMR): Proof of immunity (through bloodwork) 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 uploaded to Synergy.** *Serology valid for 10 years.*

   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 uploaded to Synergy.**
   MMR Dose 1 (dd/mm/yy):_____ **MMR Dose 2 (dd/mm/yy):** _____

Varicella: Proof of immunity (through bloodwork) 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 uploaded to Synergy.** *Serology valid for 10 years.*
   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 uploaded to Synergy.**
   Varicella Dose 1 (dd/mm/yy): _____**Varicella Dose 2 (dd/mm/yy):** _____

Tetanus/Diphtheria/Pertussis (Tdap): Completion of the initial series is required with a Tetanus booster, if more than 10 years has passed since the last dose. **A copy of the immunization record must be uploaded to Synergy.**

1. **Tdap series completed (dd/mm/yy):**_____
2. **Tetanus Booster completed (dd/mm/yy):**_____

If the student has not completed the initial series (or does not have record), 2 doses are required. **A copy of the immunization record must be uploaded to Synergy.**

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

Pertussis: Students are required to provide documentation of the Pertussis vaccine. *The OHA Pertussis Surveillance Protocol for Ontario Hospitals states that all adult HCW's (including students) are required to provide proof of an adult dose of Tdap received on or after their 18th birthday.* **A copy of the immunization record must be uploaded Synergy.**

1. **Adult dose received (dd/mm/yy):** _____ **Age at time of adult dose:** _____

Section A: To be completed by Healthcare Provider

Polio: Completion of the initial series is required. **A copy of the immunization record must be uploaded to Synergy.**

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

If the student has not completed the initial series (or does not have record), 2 doses are required. **A copy of the immunization record must be uploaded to Synergy.**

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

Hepatitis B: Proof of immunity to Hepatitis B is required through bloodwork. If non-reactive, 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 uploaded to Synergy.** *Serology valid for 10 years.*
   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 uploaded to Synergy.**
   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):**_____

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

Dose 1 received (dd/mm/yy): _____**Dose 2 received (dd/mm/yy):** _____

Additional vaccines may be required at the request of the placement agency. It is the student's responsibility to ensure they are following the agency health and safety policies.

Additional dose received (dd/mm/yy): _____

Influenza: An annual seasonal flu shot is required. The influenza vaccine is available from October to March. **Documentation of the influenza vaccine clearly indicating the date received must be uploaded to Synergy.**

Influenza Received (dd/mm/yy): _____

Section B: Non-Medical Requirements - Student Reference

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 uploaded to Synergy.**

Please use the check boxes as a reference to ensure you have all of the mandatory non-medical requirements.

☐ **CPR – BLS Certificate**
**Level C will not be accepted*

☐ **Standard First Aid Certificate**

☐ **Mask Fit Testing**

☐ **Vulnerable Sector Police Check**

☐ **WSIB Declaration**

☐ **WHMIS Certificate**

☐ **Workplace Health and Safety**

☐ **Non-Violent Crisis Intervention**

Section C: Must be completed by the student

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