Professional Practice Health Form
School of Community Studiess – GIP2

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): _____

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):** _____

Dose 3 received (dd/mm/yy): _____ **Additional Dose (dd/mm/yy):** _____

Influenza: An annual seasonal flu shot is mandatory. 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 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 – Level C Certificate**
- ☐ **Standard First Aid Certificate**
- ☐ **Police Vulnerable Sector Check**
- ☐ **WSIB Declaration**
- ☐ **Placement Agreement**

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):**_____

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PLACEMENT AGREEMENT

Thank you for accepting our offer of admission. An essential component of your education will be experiential learning through clinical or field practice relevant to your chosen profession. In order to ensure high standards and quality educational offerings which will permit students maximum opportunities to achieve learning objectives, Fanshawe College reserves the right to place students in an agency or combination of agencies it determines to be appropriate. **While every effort is made to maximize use of local agencies, there is sometimes a need to place students outside of the area for some programs or portions of programs.**

Accordingly, your admission is subject to the condition that you must be prepared for the possibility of assignment to experiential learning outside of the area, and for the possibility of having to relocate, at your own expense, for all or a portion of this experience. You are responsible for all costs associated with Clinical and/or Field Placement, (including volunteer hours).

Please indicate your understanding and acceptance of this condition by completing ALL information and signing below.

We look forward to welcoming you as a student at Fanshawe College.

"I understand and accept the condition stated above"

STUDENT NAME (Please print): _____

STUDENT NUMBER: _____

PROGRAM: _____ **START DATE:** _____

STUDENT SIGNATURE: _____ **DATE:** _____

****IMPORTANT****

Being punctual for your placement is a major contributor to how others see you in your field. Being on time, every time, is an expectation that all students should strive to achieve.

Training Participant Declaration of Understanding

Workplace Safety and Insurance Board or Private Insurance Coverage

Unpaid Work Placements

Training Participant coverage while on placement

Training Participants are eligible for Workplace Safety Insurance Board (WSIB) coverage of claims while on unpaid placements as required by their program of study. Ministry of Advanced Education and Skills Development (MAESD) also provides private insurance to students should their unpaid placement required by their program of study take place with an employer who is not covered under the *Workplace Safety and Insurance Act.*

MAESD ensures that students on work placements receive WSIB for Placement Employers who have WSIB coverage and private insurance for employers who are not covered by WSIB for injuries or disease incurred while fulfilling the requirements of their placement.

Declaration

I have read and understand that WSIB or private insurance coverage will be provided through the MAESD while I am on training placements as arranged by the College as a requirement of my program of study.

I understand the implications and have had any questions answered to my satisfaction.

I agree to immediately report any placement related injury or disease to the Placement Employer and my placement coordinator.

Release of Information

I understand that my personal information will be released to the Placement Employer in the event of a workplace injury or disease at the Placement Employer's workplace during an unpaid placement.

I understand that the MAESD, the College and the Placement Employer will be required to release relevant personal information with each other and to the WSIB or a private insurance company.

Training Participant Name (print): _____

Program/School: _____

Date: _____

Signature: _____