

Clinical Student Pre-Placement Health Review

First Name: _____ Last Name: _____

Contact #: _____ Date of Birth: (D) _____ (M) _____ (Y) _____

The following must be completed prior to your start date. This form and all supporting documents must be provided to the Student Registrar at the time of your appointment in order to clear you and your placement can begin at WRH.

1. TB Skin Test is mandatory and must be completed within 4 weeks of your start date as outlined by the OHA and OMA.

One of the following is required:

- a) 2-step Mantoux skin test if the individual has not had previous TB (Mantoux) testing.
- b) 1-step Mantoux skin test if the individual has received 1 Mantoux skin test within the last 12 months (documented proof is required).
- c) If you have had at least 2 negative TB (Mantoux) in the past with documentation, you only require one step TB testing.
- d) Passports to Health are acceptable providing the document is signed, stamped and dated by a Health Care provider within the last 12 months.

FORM IS TO BE COMPLETED BY A PROFESSIONAL HEALTH CARE PROVIDER

Dates of prior TB Skin Testing _____ Results: _____

1-Step: _____
 Date Given _____ Date Read (at 48-72 hours) _____ Result _____ Lot # / Exp/Signature _____

2-Step: _____
 Date Given _____ Date Read (at 48-72 hours) _____ Result _____ Lot # / Exp/Signature _____
(2nd test in opposite arm at least 1 week & no more than 4 weeks after the first skin test)

If the TB skin test was positive a Chest X-Ray is required.

Date of Chest X-Ray _____ Results of Chest X-Ray _____

Patient is free and clear of active TB disease? YES NO => explain: _____

2. MEASLES, MUMPS, RUBELLA & VARICELLA IMMUNIZATION REQUIREMENTS

(MMR vaccine should not be given before TB skin testing completed)

<p style="text-align: center;">Measles Immunization – ONE of the following is required:</p> <ul style="list-style-type: none"> 2 documented doses of live measles virus vaccine on or after 1st birthday OR, Lab evidence of immunity 	<p style="text-align: center;">Immunization Documentation Please complete where applicable (d/m/y)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 70%;">Date of MMR # 1</td><td></td></tr> <tr><td>Date of MMR # 2</td><td></td></tr> <tr><td>Varicella # 1</td><td></td></tr> <tr><td>Varicella # 2</td><td></td></tr> </table>	Date of MMR # 1		Date of MMR # 2		Varicella # 1		Varicella # 2	
Date of MMR # 1									
Date of MMR # 2									
Varicella # 1									
Varicella # 2									
<p style="text-align: center;">Mumps Immunization – ONE of the following is required:</p> <ul style="list-style-type: none"> 2 documented doses of MMR vaccine on or after 1st birthday OR, Lab evidence of immunity. 	<p style="text-align: center;">Serology Results Please complete where applicable (d/m/y)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 70%;">Measles</td><td></td></tr> <tr><td>Mumps</td><td></td></tr> <tr><td>Rubella</td><td></td></tr> <tr><td>Varicella</td><td></td></tr> </table>	Measles		Mumps		Rubella		Varicella	
Measles									
Mumps									
Rubella									
Varicella									
<p style="text-align: center;">Rubella Immunization – ONE of the following is required:</p> <ul style="list-style-type: none"> 1 documented dose of MMR on or after 1st birthday OR, Lab evidence of immunity. 	<p style="text-align: center;">Additional Evidence of Immunity (must be verified by a healthcare provider) Please complete where applicable (d/m/y)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 70%;">History of chicken pox</td><td style="text-align: center;">Serology required</td></tr> <tr><td>History of shingles</td><td></td></tr> </table>	History of chicken pox	Serology required	History of shingles					
History of chicken pox	Serology required								
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<p style="text-align: center;">Chicken Pox (Varicella) – ONE of the following is required:</p> <ul style="list-style-type: none"> Lab evidence of immunity OR Documented evidence of 2 doses of varicella vaccine if non-immune Verbal knowledge will still require serology evidence before a placement can begin 									

Signature/Stamp Medical Clinic or Physician _____ Date _____

COMPLETE BACK PAGE REGARDING INFLUENZA VACCINE INFORMATION

3.

INFLUENZA DOCUMENTATION

Influenza Vaccine

The influenza vaccine is recommended between October and April. Please indicate if you have received the vaccine for this period.

Yes (date given, d/m/y): _____ No _____

If influenza vaccine not received, was vaccine offered:

Yes _____ No _____ Vaccine accepted _____ or Vaccine declined _____

You may contact the Public Health Unit to request a free copy of your immunization record. Go to www.alphaweb.org and click on Public Health Units-Ontario for the contact information of the Public Health in the city/county you attended grade school or high school. To contact Windsor-Essex County Public Health Unit, call 519-258-2146, Ext 1425.

References:

Joint Committee on Communicable Disease and Surveillance Protocols, *Communicable Disease Surveillance Protocol for Ontario Hospitals*. Ontario Hospital Association, Ontario Medical Association.