HUMBER COLLEGE

PRE-PLACEMENT CLINICAL REQUIREMENTS – FIRST YEAR PSW STUDENTS

THE INFORMATION YOU PROVIDE IS CONFIDENTIAL. IT IS INTENDED FOR USE BY THE HUMBER COLLEGE OFFICE OF EXPERIENTIAL LEARNING IN ORDER TO ENSURE THAT THE STUDENT MEETS THE IMMUNIZATION REQUIREMENTS FOR CLINICAL PLACEMENT.

FIRST NAME: _____ **LAST NAME:** _____

STUDENT ID #: _____ **DATE OF BIRTH:** _____

CONTACT #: _____ **E-MAIL:** _____

MANDATORY MEDICAL REQUIREMENTS

HEALTH CARE PROVIDER (HCP) MUST COMPLETE ENTIRE FORM IN FULL

1 - TUBERCULOSIS (TB):

- A two-step Tuberculin Skin Test is required only once in your lifetime if properly performed and documented and MUST be presented at initial placement prerequisites clearance appointment.
- **A TB Skin Test (EITHER a two-step - if you have never had a two-step OR a one-step - if you have had a documented two-step) is required after January 1st of the current academic year.**
- If the student has a documented history of a negative TB Skin Test, then the student MUST have a Single-Step TB Skin Test.
- If the student has a documented history of a previous positive TB Skin Test (induration measuring equal to or greater than 10mm) or Active TB, a TB Skin Test is NOT REQUIRED. Proceed to Chest X-Ray and Chest Assessment.

TB TEST	VACCINE NAME	DATE GIVEN	SITE/ ROUTE/ DOSE	DATE READ (48-72 HOURS FROM TEST)	RESULT: INDURATIONS IN (MM)	HCP INITIAL
STEP 1		MM/DD/YY		MM/DD/YY		
STEP 2 (7-28 DAYS AFTER STEP 1)		MM/DD/YY		MM/DD/YY		

IF EITHER TB SKIN TEST STEP IS POSITIVE (= TO OR > THAN 10 MM INDURATION), PLEASE EVALUATE AS FOLLOWS

CHEST X-RAY: ATTACH A COPY OF CHEST X-RAY RESULTS - MANDATORY ☐

CHEST X-RAY DATE	CHEST X-RAY RESULTS	INH TREATMENT PRESCRIBED (YES OR NO)
MM/DD/YY		

CHEST ASSESSMENT: Students with a positive TB Skin Test and AFTER one Chest X-Ray, MUST have their HCP assess their chest annually and document that they are free from TB signs and symptoms and that the student does not have active TB:

CHEST ASSESSMENT DATE	CHEST ASSESSMENT RESULTS (NEGATIVE= NO SYMPTOMS OF TB) (POSITIVE= SYMPTOMS OF TB)	HCP INITIAL
MM/DD/YY		

HUMBER

IMMUNIZATION RECORDS & LABORATORY BLOOD TESTS REQUIRED

A COPY OF YOUR IMMUNIZATION RECORD IS REQUIRED.
YOU MAY CONNECT WITH PUBLIC HEALTH-CANADA TO OBTAIN A COPY OF YOUR EXISTING RECORDS.
NOTE: ANY LIVE VACCINATION **MUST** BE DONE ON THE SAME DAY AS TB SKIN TESTING **OR** DELAYED AT LEAST 4 WEEKS AFTER LIVE VACCINE ADMINISTRATION.

2 - TETANUS / DIPHTHERIA / PERTUSSIS (Tdap): If the student has not received Pertussis as an adolescent (Age 14 +) or adult, they require one Adacel Vaccination. Even if you have a current dose of Tetanus/Diphtheria (T/d) in the last 10 years you will need one dose of Adacel in adulthood. A T/d booster is required every 10 years.

IMMUNIZATION	VACCINE NAME	DATE GIVEN	SITE/ROUTE/DOSE	HCP INITIAL
TETANUS/DIPHTHERIA/PERTUSSIS (ADACEL - AGE = TO OR > THEN 14 YEARS)		MM/DD/YY		
TETANUS/DIPHTHERIA (T/d) (EVERY 10 YEARS)		MM/DD/YY		

3 - MEASLES / MUMPS / RUBELLA (MMR): Documentation proof of 2 MMR vaccines or laboratory blood test results proving immunity to Measles, Mumps, and Rubella is required.

- If blood work results show the student is not immune or indeterminate to Measles, Mumps and/or Rubella and there is no history of vaccination with MMR, then 2 MMR vaccines, given at least 4 weeks apart are required.
- If blood work results show the student is not immune or indeterminate to Measles, Mumps and/or Rubella and the student has documented evidence of 1 MMR then 1 MMR booster is required.

ATTACH A COPY OF M/M/R BLOOD TEST RESULTS – IF REQUIRED OR COMPLETE VACCINES ☐

VACCINE NAME	DATE GIVEN	SITE/ROUTE/DOSE	HCP INITIAL
MMR #1	MM/DD/YY		
MMR #2	MM/DD/YY		
MMR BOOSTER (ONLY IF REQUIRED)	MM/DD/YY		

4 - VARICELLA (CHICKENPOX): Documentation proof of 2 Varicella vaccines or laboratory blood test results proving immunity to Varicella is required regardless of history of illness.

- If blood work results show the student is not immune to Varicella and there is no history of vaccination with Varicella, then 2 doses of the Varicella vaccination, given at least 4 weeks apart are required.

ATTACH A COPY OF VARICELLA BLOOD TEST RESULTS – MANDATORY ☐

VACCINE NAME	DATE GIVEN	SITE/ROUTE/DOSE	HCP INITIAL
VARICELLA DOSE # 1	MM/DD/YY		
VARICELLA DOSE # 2	MM/DD/YY		

5 - INFLUENZA (FLU): Annual Flu shots are mandatory; every October or when the vaccine becomes available.

IMMUNIZATION	VACCINE NAME	DATE GIVEN	SITE/ROUTE/DOSE	HCP INITIAL
INFLUENZA (ANNUAL)		MM/DD/YY		

HUMBER

6 - HEPATITIS B (HB):

- Initial laboratory blood tests for Hepatitis B Antibodies (HBsAb) and Hepatitis B Antigen (HBsAg) results are mandatory.
- Documented proof is required if you have received 2 doses of Hepatitis B in grade 7 or 3 doses of Hepatitis B as an adult.
- If blood work results show the student is not immune after the two grade 7 vaccine doses or 3 adult doses, then a Hepatitis B Booster is required; and the student MUST follow-up with a blood test for HBsAb and HBsAg after 4-6 weeks to check immunity.
- If blood work results show the student is not immune and there is no history of vaccination with Hepatitis B, then 3 Hepatitis B vaccines are required; and the student MUST follow-up with a blood test for HBsAb and HBsAg after 4-6 weeks following the 3rd vaccine to check immunity.
- If the student is still not immune to Hepatitis B after the Booster, the student is required to complete the 2nd series – 2 more Hepatitis B vaccines; and the student MUST follow-up with a blood test 4-6 weeks after the second full series to check immunity.

AT LEAST 2 OF 3 DOSES OF THE HEPATITIS B VACCINE OR PROOF OF IMMUNITY ARE REQUIRED TO BEGIN CLINICAL PLACEMENT.

Hepatitis B Vaccination Schedule:

Regular Schedule: 0 Month, 1 Month, 6 Months **OR** Rapid Schedule: 0 Day, 7 Days, 21 Days, 12 Months

ATTACH A COPY OF HEPATITIS B (HBsAb) AND (HBsAg) BLOOD TEST RESULTS – MANDATORY ☐

VACCINE NAME: (RECOMBIVAX HB, ENGERIX B OR TWINRIX)	DATE GIVEN	SITE/ROUTE/DOSE	HCP INITIAL
NAME: _____	MM/DD/YY		
NAME: _____	MM/DD/YY		
NAME: _____	MM/DD/YY		

VACCINE NAME: (RECOMBIVAX HB, ENGERIX B OR TWINRIX)	DATE GIVEN BOOSTER VACCINES (ONLY IF REQUIRED)	SITE/ROUTE/DOSE	HCP INITIAL
NAME: _____	MM/DD/YY		
NAME: _____	MM/DD/YY		
NAME: _____	MM/DD/YY		

ATTACH A COPY OF HEPATITIS B (HBsAb) POST BOOSTER BLOOD TEST RESULTS – MANDATORY ☐

IF STUDENT IS NOT IMMUNE TO HEPATITIS B AFTER SECOND FULL SERIES, BOOK A FOLLOW-UP APPOINTMENT WITH YOUR HCP

HEALTH CARE PROVIDER INFORMATION (HCP):

NOTE TO HCP: IF THERE ARE ANY INCOMPLETE ITEMS ON THIS FORM DUE TO MEDICAL, PREGNANCY, RELIGIOUS OR OTHER REASONS, PLEASE PROVIDE A NOTE TO YOUR PATIENT/STUDENT TO EXPLAIN THE REASON.

HCP NAME (PLEASE PRINT): _____ **HCP INITIAL:** _____

HCP SIGNATURE: _____ **HCP LICENSE #:** _____

PROFESSION (PLEASE CIRCLE): RPN RN NP MD **DATE:** _____

ADDRESS/CLINICAL STAMP:

STUDENTS: ONCE YOU HAVE COMPLETED ALL YOUR PRE-PLACEMENT REQUIREMENTS; USE THIS ONLINE LINK TO BOOK AN APPOINTMENT FOR PRE-PLACEMENT CLEARANCE: HTTPS://HUMBERHEALTH.MYWCONLINE.COM.