HUMBER COLLEGE

PRE-PLACEMENT CLINICAL REQUIREMENTS – RETURNING BN SECOND ENTRY 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 one-step Tuberculin Skin Test is required 12 months within the start of your placement.
- 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		

IF STEP 1 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		

2 - TETANUS / DIPHTHERIA (Td): A Tetanus/Diphtheria (T/d) booster is required every 10 years.

IMMUNIZATION	VACCINE NAME	DATE GIVEN	SITE/ROUTE/DOSE	HCP INITIAL
TETANUS/DIPHTHERIA (T/d) (EVERY 10 YEARS)		MM/DD/YY		

3 – 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		

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.