Pre-Placement Health Form

Student Instructions

Program and Student Details

Student Name: _____ **Student ID:** _____

Program Name: Biotechnology - Advanced **Code (#):** K0437 **Year:** _____

Requirements Due: _____

Student Instructions for Mandatory Requirements

1. Review the requirements checklist below:

SECTION	REQUIREMENT	Ensure all requirements are complete with records and certificates included
Section A – Medical Requirements *(Completed and signed by Health Care Provider)*	Tuberculosis (TB) Screening	☐
	Measles Mumps and Rubella (MMR)	☐
	Varicella (Chickenpox)	☐
	Tetanus/Diphtheria (Td)	☐
	Pertussis	☐
	Polio	☐
	Hepatitis B	☐
	Meningococcal Vaccine	☐

2. Access the **St. Lawrence College Placement Pass** website for the most current Pre-Placement Health Form Package: https://slc.placementpass.ca/
3. Book an appointment with a Physician or Nurse Practitioner.
4. Bring vaccine records, public health forms or documents (including childhood records) that show your immunization history to your appointment.
5. Provide **Section A** (instructions and forms) to your health care provider to complete and sign/stamp.
   ***Note**: RNs/RPNs may also co-sign portions of the form.*
6. Ensure your Health Care Provider (HCP) provides you with the following documents so you can submit these to Placement Pass with the health forms:
   a. Vaccine records (for proof of immunization).
   b. Lab blood test results.
   c. Chest X-ray report, if required.
7. Complete checklist (above) to ensure all requirements are met for Section A:
   a. Section A (all pages) completed, initialed, and signed by your Health Care Provider.
   b. Your blood lab reports and, if required, chest X-Ray report.
   c. Your immunization vaccine records including childhood records, if available. Ensure your **NAME** is on each record.
8. Scan, label, and submit all documents to the website located at https://slc.placementpass.ca/

- Students who started a vaccine series will receive a temporary exception after two doses.
- Verify that documents are clear and legible before submitting them to the Placement Pass.
- Ensure vaccine records that are not in English include the original document and an officially translated English copy.

Pre-Placement Health Form

Health Care Provider Instructions

Health Care Provider Instructions for Mandatory Medical Requirements

1. Complete Section A in its entirety and provide an attesting signature/initial where indicated.
2. Provide the student a copy of vaccine records for vaccines administered and lab results for lab tests completed.
   ***Note**: Immunization requirements listed follow the standards outlined in: The Canadian Immunization Guide (Part 3) **Vaccination of Specific Populations** - Workers and Student Placements, The Canadian Tuberculosis Standards (2007), and the OHA/OMA Ontario Hospitals Communicable Disease Surveillance Protocols.*
3. Use the following instructions when completing the following subsections:

   a. Tuberculosis (TB) Screening:
   - i. 2-step TB Mantoux skin test is required regardless of BCG history. TB tests should be given 1 to 3 weeks apart.
   - ii. TB test is invalid if it is given in the 30-day period following the administration of any live vaccines. Ensure TB testing is complete before giving any live vaccines (e.g., MMR, Varicella).
   - iii. If a student was positive from a previous 2-step skin test, a TB test is not required; instead, proceed to a chest X-ray.
   - iv. For any student who has completed a negative 2-step TB test, complete a 1-step only. Documentation of the initial 2-step TB test must still be submitted.
   - v. For any student who tests positive:
     - Include date and results from any previous positive TB skin testing.
     - A chest X-ray is required (within 6 months prior to the start of placement, valid for 2 years).
     - Indicate any treatments that have been started.
     - Complete assessment and document on form if the student is clear of signs and symptoms of active TB. This is an annual requirement.

   b. Measles Mumps and Rubella (MMR):
   - i. Option 1 – Vaccine records of 2 doses of MMR vaccine is required.
   - ii. Option 2 – Provide lab blood test showing full immunity. If the lab blood test does not show full immunity, an MMR booster dose is required.
     ***Note:** This vaccine is not recommended (contraindicated) when pregnant. Pregnancy should be avoided for 3 months post immunization.*

   c. Varicella (Chickenpox):
   - i. Either vaccine records of 2 doses of Varicella vaccine or a lab blood test showing evidence of full immunity are required.
     ***Note:** This vaccine is not recommended (contraindicated) when pregnant. Pregnancy should be avoided for 3 months after a Varicella vaccination has been given.*

   d. Tetanus/Diphtheria (Td) and Pertussis:
   - i. Vaccine records showing an initial primary series are required.
   - ii. If there are no records available, give adult primary series of 3 doses. Dose #1 should be Tdap.
     Note:** National Advisory Commission on Immunization (NACI) as well as the OHA Surveillance Protocols recommends that all adults regardless of age should receive a single dose of tetanus diphtheria acellular pertussis (Tdap) for pertussis protection if not previously received in adulthood. The adult dose is in addition to the routine adolescent booster dose. The interval between the last tetanus diphtheria booster and the Tdap vaccine does not matter. **All students are required to provide proof of an adult dose of Tdap received on or after their 18th birthday.

e. Polio:

i. Vaccine records showing an initial primary series are required.
ii. If there are no records available, then give an adult primary series of 3 doses.

f. Hepatitis B:

i. If previously immunized, a lab test must be obtained for evidence of immunity (anti-HBs/HBsAb). Copies of lab results must be provided.
ii. If the student has a completed initial primary series documented and serology results are < 10 IU/L, provide a booster dose. Another lab test 30 days following the booster is required to confirm immunity. Or, provide a second vaccine series.
iii. If the student has not received the Hepatitis B vaccine provide the initial primary series as follows:
- Dose #1 – as soon as possible.
- Dose #2 – one month after dose #1.
- Dose #3 – six months after dose #1 → serology is required 30 days following dose #3.

iv. If serology results are < 10 IU/L, dose #4 is required, followed by another lab test 1 month after.
- If serology results remain < 10 IU/L, continue with the vaccine series until completion, with repeat lab test 1 month after the final dose (*may receive up to 6 doses).

g. Meningococcal Vaccine:

i. Documented proof of receiving the quadrivalent meningococcal vaccine (MenC-ACYW-135) vaccine is required. A booster dose should be administered if primary dose was administered greater than 5 years prior.
ii. Serogroup B meningococcal vaccine (4CMenB or MenB-fHBP) is highly recommended.

4. Complete Health Care Provider Signature and Identification subsection.
i. To be completed by each health care provider who has provided information in Section A (to match initials on the form to signature).

Pre-Placement Health Form

SECTION A: Health Care Provider Form

!	► Do not leave any sections blank – If not applicable, please complete with "N/A". If drawn, provide the student with a copy of the lab report/results (attach laboratory blood report) for each of the following:

Student Name: _____ **Student ID:** _____

TUBERCULOSIS (TB) SCREENING **Initial 2-Step Mantoux Test – Mandatory**	**Date Administered**	**Date Read** (48-72 hours from testing)	**Results*** (Induration in mm)
1-step	YYYY/MM/DD	YYYY/MM/DD	_____ mm
2-step (7-28 days after 1-step)	YYYY/MM/DD	YYYY/MM/DD	_____ mm
1-step if the initial 2-step TB skin test has been completed previously with negative results. Record date of previous 2-step in space above.	YYYY/MM/DD	YYYY/MM/DD	_____ mm

*10 mm or more: ☐ Positive ☐ Negative ☐ N/A Date of Chest X-Ray: YYYY/MM/DD

Signs/symptoms of active TB on physical exam? ☐ Yes ☐ No Date of Assessment: YYYY/MM/DD

Health Care Provider Initials: ( )

MEASLES MUMPS AND RUBELLA (MMR)	**Dose 1**	**Dose 2**
OPTION #1 – Date of Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
OPTION #2 – Serology Date of test (attach lab report): _____	Immune to Measles: ☐ Yes ☐ No Immune to Mumps: ☐ Yes ☐ No Immune to Rubella: ☐ Yes ☐ No If serology not immune: Date of MMR booster: _____	

Health Care Provider Initials: ( )

VARICELLA (CHICKENPOX)	**Dose 1**	**Dose 2**
Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD

Immune to Varicella? Attach lab report. ☐ Yes ☐ No Health Care Provider Initials: ( )

TETANUS/DIPHTHERIA (TD) AND PERTUSSIS	**Tdap Booster**	**Dose 2**	**Dose 3**
Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD

Initial primary series completed? Attach vaccination records. ☐ Yes ☐ No (If no, provide primary series of 3 doses)

Received one dose of **Tdap** after 18th birthday? ☐ Yes ☐ No Health Care Provider Initials: ( )

POLIO	**Dose 1**	**Dose 2**	**Dose 3**
Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD

Initial primary series completed? Attach vaccination records. ☐ Yes ☐ No (If no, provide primary series of 3 doses)

Health Care Provider Initials: ( )

Pre-Placement Health Form

SECTION A: Health Care Provider Form

Student Name: _____ **Student ID:** _____

HEPATITIS B		Dose 1	Dose 2	Dose 3	Booster
Initial Series	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD
	Product Name:				
Second Series	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD		
	Product Name:				

Immune to Hepatitis B? Attach lab report. ☐ Yes ☐ No

Do lab test results one-month **post final dose** indicate "Immune Hepatitis B"? ☐ Yes ☐ No ☐ N/A

Health Care Provider Initials: ( )

MENINGOCOCCAL VACCINE		Dose 1	Booster
MenC-ACYW-135	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		
Serogroup B Meningococcal (recommended)	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		

Health Care Provider Initials: ( )

Pre-Placement Health Form

SECTION A: Health Care Provider Form

Student Name: ______________________________ **Student ID:** ______________

Health Care Provider Signature & Identification		
		Professional Identification Stamp:
Printed Name:		
Signature:		
Initials:		
Designation:	☐ MD ☐ RN (EC) ☐ RN/RPN ☐PA	
Phone Number:	( ) -	

Health Care Provider Signature & Identification		
		Professional Identification Stamp:
Printed Name:		
Signature:		
Initials:		
Designation:	☐ MD ☐ RN (EC) ☐ RN/RPN ☐PA	
Phone Number:	( ) -	

Health Care Provider Signature & Identification		
		Professional Identification Stamp:
Printed Name:		
Signature:		
Initials:		
Designation:	☐ MD ☐ RN (EC) ☐ RN/RPN ☐PA	
Phone Number:	( ) -	