Pre-Placement Health Form

Student Instructions

Program and Student Details

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

Program Name: Early Childhood Education **Code (#):** C0302 / K0682 **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)*	Measles Mumps and Rubella (MMR)	☐
	Varicella (Chickenpox)	☐
	Tetanus/Diphtheria (Td)	☐
	Pertussis	☐
	Polio	☐
	Hepatitis B	☐
	Meningococcal Vaccine	☐
	Influenza	☐
	COVID-19	☐
Section B – Non-Medical Requirements	CPR Level C	☐
	Standard First Aid	☐
	Vulnerable Sector Check	☐

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 **Section B:** Mandatory Non-Medical Requirements.
8. Complete checklist (above) to ensure all requirements are met for both sections (A & B):
   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.
   d. Section B certificates or proof of completion for any non-medical requirements.
9. 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. Measles Mumps and Rubella (MMR):
   i. Individuals born before 1970 are considered immune and no immunization is required.
   ii. Adults born in or after 1970 require two doses of MMR or laboratory evidence of immunity.
   ***Note:** This vaccine is not recommended (contraindicated) when pregnant. Pregnancy should be avoided for 3 months post immunization. MMR and Varicella are live vaccines and must be given on the same day or at least 28 days apart.*

   b. Varicella (Chickenpox):
   i. Option 1 – Vaccine records of 2 doses of Varicella is required.
   ii. Option 2 – Provide laboratory blood test showing evidence of full immunity.
   iii. Option 3 – A self-reported history of chickenpox disease may be considered acceptable. If the individual is unsure of their history, consider serologic testing or vaccination, as appropriate. Adults who have not had chickenpox disease after 1 year of age should receive two doses of Varicella vaccine at least 6 weeks apart.
   ***Note:** This vaccine is not recommended (contraindicated) when pregnant. Pregnancy should be avoided for 3 months post immunization. MMR and Varicella are live vaccines and must be given on the same day or at least 28 days apart.*

   c. Tetanus/Diphtheria (Td) and Pertussis:
   i. After a Tetanus, Diphtheria, and Pertussis booster (Tdap) at age 14-16, an additional Tdap is required in adulthood (>18) ten years after the previous dose. Following an adulthood dose of Tdap, a booster of Tetanus and Diphtheria (Td) is required every 10 years for life.
   ii. Adults who have not previously received Tdap in adulthood (>18), should be immunized regardless of the interval since their last dose of tetanus or diphtheria containing vaccine.
   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.

   d. Polio:
   i. Vaccine records showing an initial primary series are required.
   ii. Adults who did not receive immunization against Polio in childhood should receive an adult primary series of 3 doses – two doses of an IPV-containing vaccine to be given 4 to 8 weeks apart, followed by a third dose 6 months after the second dose.

e. 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).

f. Meningococcal Vaccine:

i. Adults born between 1986 and 1996 should have or receive one dose of Meningococcal Conjugate C (Men-C-C).

ii. Adults born in or after 1997 should have received both Men-C-C and Meningococcal Conjugate ACYW-135 (Men-C-ACYW-135).

g. Influenza (Flu):

i. Only applicable during flu season (October to the end of April).

ii. Influenza immunization is recommended for healthy adults in close contact with children less than 5 years of age or other high-risk individuals.

iii. If a medical exemption to flu vaccination is indicated, the document must follow current NACI recommendations.

Note: *Student must sign the influenza waiver if they do not intend to get the seasonal flu shot (see Section A, page 2)*.

Only applicable during flu season (October to the end of April). An annual Influenza immunization is recommended every year in the fall for healthy individuals.

h. COVID-19:

i. COVID-19 immunization is recommended for the indicated program.

ii. Adults ≥ 18 years of age should complete an approved primary immunization series for COVID-19 and receive appropriate booster doses as per the Ministry of Health recommendations and eligibility.

iii. If a medical exemption to COVID-19 vaccination is indicated, a medical note is required which follows the process as outlined in the current NACI guidelines for a physician requested medical exemption of COVID-19 immunization. It must include:

- The medical reason they cannot be vaccinated for COVID-19, and
- The effective time period for the medical reason (i.e., permanent or time-limited).

Note: *Student must sign the COVID-19 waiver if they do not intend to get some or any of the COVID-19 immunization doses (see Section A, page 2)*.

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:** _____

MEASLES MUMPS AND RUBELLA (MMR)	Dose 1	Dose 2
OPTION #1 – Date of Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
OPTION #2 – Serology	Immune to MMR (attach lab report): ☐ Yes ☐ No	

Health Care Provider Initials: ( )

VARICELLA (CHICKENPOX)	Dose 1	Dose 2
OPTION #1 – Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
OPTION #2 – Serology	Immune to Varicella (attach lab report): ☐ Yes ☐ No	
OPTION #3 – Self-Reported History	Date of disease: YYYY/MM/DD	

Health Care Provider Initials: ( )

TETANUS/DIPHTHERIA (TD) AND PERTUSSIS	Date Vaccine Administered
Tdap booster:	YYYY/MM/DD
Td booster:	YYYY/MM/DD

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: ( )

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	Date Vaccine Administered
Meningococcal Conjugate C (Men-C-C)	YYYY/MM/DD
Meningococcal ACYW-135 (Men-C-ACYW-135)	YYYY/MM/DD

Health Care Provider Initials: ( )

Pre-Placement Health Form

SECTION A: Health Care Provider Form

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

INFLUENZA (FLU)	**Seasonal Dose**
Date Vaccine Administered:	YYYY/MM/DD
Product Name:	
Provide vaccine record or Health Care Provider signature:	
Influenza Waiver: Students who choose not to have the annual influenza vaccine for medical or personal reasons must sign to acknowledge their awareness of susceptibility to the disease and of the implications for clinical placement and lost time.	I understand that the Academic Program encourages students to have an annual influenza vaccine. I have selected to waive this immunization based on medical and/or personal reasons. I am aware that I may be susceptible to influenza, and I understand that I may not be eligible to attend clinical placement. **Student Signature**: _____

COVID-19		**Dose 1**	**Dose 2**
Full Series *Provide vaccine record*	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		
Booster Dose(s) *Provide vaccine record*	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		
COVID-19 Waiver: Booster doses are strongly recommended as these requirements are based on the placement organizations and their policies and subject to change.		By signing this waiver, I understand that if I fail to submit proof of vaccination for COVID-19 or medical documentation outlining why I am unable to receive the COVID-19 vaccine, I may be unable to attend clinical placement due to placement agency requirements, thereby jeopardizing successful completion of the program. **Student Signature**: _____	

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:	( ) -	

Pre-Placement Health Form

SECTION B: Mandatory Non-Medical Requirements

Program and Student Details

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

Program Name: Early Childhood Education **Code (#):** C0302 / K0682 **Year:** _____

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- ► Review your communication from your program to find out when to obtain these requirements including **date to apply** and any other special instructions.
- ► Ensure annual requirements **remain valid** until completion of your academic year.
- ► Submit supporting documents in PDF format, if possible.
- ► Verify that documents are clear and legible before submitting to the Placement Pass website.

NON-MEDICAL REQUIREMENTS
CPR Level C – valid for 3 years
Standard First Aid – valid for 3 years
Vulnerable Sector Check (VSC) – valid for 1 year