Pre-Placement Health Form

Student Instructions

Program and Student Details

Student Name:	**Student ID:**	
Program: Paramedic	**Code (#):** C0970	**Year:**
Requirements Due:		

Student Instructions for Mandatory Requirements

1. Review the Requirements Checklist (page 13).
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. RNs/RPNs may also co-sign 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:** Other Medical Requirements and **Section C:** Mandatory Non-Medical Requirements.
8. Complete checklist to ensure requirements are met for all sections (A, B & C):
    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. Ensure vaccine records that are not in English include the original document and an officially translated English copy.
    e. Section C 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/
10. Verify that documents are clear and legible before submitting them to the Placement Pass.

Pre-Placement Health Form

Health Care Provider Instructions

Thank you for your cooperation with the immunization process for our student registered in this program. Please provide students a copy of any vaccine records and lab results for any vaccines administered and lab tests completed. Immunization requirements listed before each section follow the standards outlined in:

The Canadian Immunization Guide (Part 3) – Vaccination of Specific Populations- Workers and Student Placements

The Canadian Tuberculosis Standards (2007)

The OHA/OMA Ontario Hospitals Communicable Disease Surveillance Protocols.

The required information with exact dates (YYYY/MM/DD) and signature for each requirement must be recorded on this Clinical Pre-placement Health Form in the shaded areas provided. Please also provide an attesting signature at the end of Section A. Failure to complete in its entirety and submit this form by the required deadline, will exclude student from their clinical/field placement.

Please read and follow all detailed instructions for these medical requirements:

TB Screening	2-step TB skin test required. If positive from previous skin testing, a medical follow-up with a chest X-Ray and assessment is needed.
Measles Mumps Rubella	Vaccine records of 2 doses of MMR vaccine are required OR a lab blood test showing full immunity.
Varicella	Vaccine records of 2 doses of Varicella vaccine are required OR a lab blood test showing full immunity.
Tetanus/Diphtheria and Pertussis	Vaccine records showing an initial primary series with one dose of Tdap as an adult is required. If no records available, give adult primary series of 3 doses. Dose #1 should be Tdap.
Polio	Vaccine records showing an initial primary series. If no records available, give adult primary series of 3 doses.
Hepatitis B	Vaccine records showing proof of a primary series of Hepatitis B vaccines AND a lab blood test must be obtained for evidence of immunity (anti-HBs/HBsAb). If not immune, provide further dosing as required.

Please ensure you have reviewed, completed, and signed the required areas in Section A.

Pre-Placement Health Form

Section A: Mandatory Medical Requirements

Student Name: _____ **Student Number:** _____

!	➢ Students who started a vaccine series will receive a temporary exception after two doses. ➢ Do not leave any sections blank – If not applicable, please complete with "N/A". If bloodwork is drawn, provide the student with a copy of the lab report/results (attach laboratory blood report) for each of the following:

Tuberculosis (TB) Screening

Instructions:

1. A 2-step TB Mantoux skin test is required regardless of BCG history. TB tests should be given 1 to 3 weeks apart.
2. 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).
3. 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.
4. If a prior negative 2-step TB test was completed, only a 1-step TB test is required. Initial 2-step documentation must still be submitted.
5. For any student who tests positive:
    a. Include date and results from any previous positive TB skin testing.
    b. A chest X-ray is required (within 1 year prior to the start of placement, valid for 2 years).
    c. Indicate any treatments that have been started.
    d. Complete assessment and document if the student is clear of signs and symptoms of active TB. This is an annual requirement.

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	
2-step (7-28 days after 1-step)	YYYY/MM/DD	YYYY/MM/DD	
Annual 1-step if prior 2-step TB test was negative	YYYY/MM/DD	YYYY/MM/DD	

If either step is positive (10 mm or more), please evaluate the following:

1. Chest X-ray results (attach report): ☐ Positive ☐ Negative ☐ N/A

   Date of Chest X-Ray: _____YYYY/MM/DD_____
2. Does this student have signs/symptoms of active TB on physical exam? ☐ Yes ☐ No

   Date of Assessment: _____YYYY/MM/DD_____

Health Care Provider Signature: _____

Pre-Placement Health Form

Section A: Mandatory Medical Requirements

Student Name: _____ **Student Number:** _____

Measles Mumps Rubella (MMR)

Instructions:

1. Either vaccine records of 2 doses of MMR vaccine is required or a lab blood test showing full immunity. If the lab blood test does not show full immunity and the student does not have any vaccine records of MMR, they will require 2 doses of MMR vaccine given 1 month apart.
2. An MMR booster is required if the student has a record of 1 dose of MMR vaccine.
   Note: *This vaccine is not recommended (contraindicated) when pregnant. Pregnancy should be avoided for 3 months post immunization.*

	Dose 1	Dose 2
Date of Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD

Immune to MMR? Attach lab report. ☐ Yes ☐ No

Health Care Provider Signature: _____

Varicella (Chickenpox)

Instructions:

1. 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.*

	Dose 1	Dose 2
Date of Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD

Immune to Varicella? Attach lab report. ☐ Yes ☐ No

Health Care Provider Signature: _____

Student Name: _____ **Student Number:** _____

Tetanus/Diphtheria (Td) and Pertussis

Instructions:

1. Vaccine records showing an initial primary series are required.
2. 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.***

	Tdap Booster	**Dose 2**	**Dose 3**
Date of 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 Signature: _____

Polio

Instructions:

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

	Dose 1	**Dose 2**	**Dose 3**
Date of 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 Signature: _____

Pre-Placement Health Form

Section A: Mandatory Medical Requirements

Student Name: _____ **Student Number:** _____

Hepatitis B

Instructions:

1. If previously immunized, a lab test must be obtained for evidence of immunity (anti-HBs/HBsAb). Copies of lab results must be provided.
2. 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.
    a. Students must provide documented proof that they have received the initial primary series for Hepatitis B vaccine.
3. If the student has not received the Hepatitis B vaccine, provide the initial primary series as follows:
    a. Dose #1 – as soon as possible.
    b. Dose #2 – one month after dose # 1.
    c. Dose #3 – six months after dose # 1 → serology is required 30 days following dose #3.
4. If serology results are < 10 IU/L, dose #4 is required, followed by another lab test 1 month after.
    a. If serology results remain < 10 IU/L, continue with the vaccine series (dose #5 and dose #6) until completion, with repeat lab test 1 month after the final dose (*may receive up to 6 doses).

Provide vaccine records or record doses administered below:

Series	Dose	Date of Vaccine Administered	Product Name
Initial Series	Dose 1	YYYY/MM/DD	
	Dose 2	YYYY/MM/DD	
	Dose 3	YYYY/MM/DD	
Post-Series / Booster	Dose 4	YYYY/MM/DD	
Second Series (if required)	Dose 5	YYYY/MM/DD	
	Dose 6	YYYY/MM/DD	

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

Do lab test results one month post **dose 4** indicate "Immune Hepatitis B"? ☐Yes ☐No ☐N/A

Do lab test results one month post **dose 6** indicate "Immune Hepatitis B"? ☐Yes ☐No ☐N/A

Health Care Provider Signature: _____

Student Name: _____ **Student Number:** _____

Reportable Communicable Diseases Statement

General Information

In Ontario, there is a list of the Reportable Communicable Diseases set out in the Ontario Regulation 559/91[1] under the *Health Protection and Promotion Act* (HPPA). These diseases must be reported to the Medical Officer of Health under the authority of HPPA[2]. The standard outlines the communicable diseases (see below) for which each EMA, paramedic and paramedic student must be free from as required by clause 6(1)(g) of O. Reg 257/00 under the *Ambulance Act*. As stated in the *Patient Care and Transportation Standards*, employees who are exhibiting an acute symptomatic illness that may be communicable should not be involved in the assessment of or direct delivery of care to a patient[3].

Acquired Immunodeficiency Syndrome (AIDS)	Food poisoning, all causes	Pertussis (Whooping Cough)
Acute Flaccid Paralysis	Gastroenteritis	Plague
Amebiasis	Giardiasis, except asymptomatic cases	Pneumococcal disease, invasive
Anaplasmosis	Gonorrhoea	Poliomyelitis, acute
Anthrax	Group A Streptococcal disease, invasive	Powassan Virus
Babesiosis	Group B Streptococcal disease, neonatal	Psittacosis/Ornithosis
Blastomycosis	Haemophilus influenzae disease	Q Fever
Botulism	Hantavirus pulmonary syndrome	Rabies
Brucellosis	Hemorrhagic fevers	Respiratory infection outbreaks
Campylobacter enteritis	Hepatitis viral A, B, C	Rubella, including congenital syndrome
Carbapenemase-producing Enterobacteriaceae	Influenza	Salmonellosis
Chancroid	Legionellosis	Shigellosis
Chickenpox (Varicella)	Leprosy	Syphilis
Chlamydia trachomatis infections	Listeriosis	Tetanus
Cholera	Lyme Disease	Trichinosis
Clostridium difficile infection (CDI) outbreaks	Measles	Tuberculosis (TB)
Coronaviruses (COVID-19, SARS, MERS)	Meningitis, acute (Bacterial, Viral)	Tularemia
Creutzfeldt-Jakob Disease, all types	Meningococcal disease, invasive	Typhoid Fever
Cryptosporidiosis	Mumps	Verotoxin-producing E. coli infection
Cyclosporiasis	Ophthalmia neonatorum	West Nile Virus (WNV)
Diphtheria	Orthopoxviruses including monkeypox, smallpox	Yersiniosis
Echinococcus multilocularis infection	Paralytic Shellfish Poisoning (PSP)	
Encephalitis	Paratyphoid Fever	

Reportable Communicable Diseases Statement (continued)

For the Physician to Complete

This student is symptom free from any communicable diseases at this time: ☐Yes ☐No

Print Name: _____

Signature: _____ **Date:** _____

For the Student to Complete

As of the date noted on this form, I _____, have not been diagnosed or to the best of my knowledge, currently infected with any of the attached noted communicable diseases. I understand that if I am diagnosed or possibly exposed to one of these diseases during my Paramedic Program studies, I will report the exposure to my local Public Health Agency where I reside as well as my St. Lawrence College program coordinator.

Signature: _____ **Date:** _____

[1]Specifications of Reportable Diseases, Health Protection and Promotion Act, Ontario Regulation 559/91 https://www.ontario.ca/laws/statute/90h07 and https://www.ontario.ca/laws/regulation/r18135

[2]Exposure of Emergency Service Workers to Infectious Disease Protocol https://files.ontario.ca/moh-infectious-disease-protocol-en-2023.pdf

[3]Patient Care and Transportation Standards, EHSB-MOHL TC, October 2007 http://ambulancetransition.com/pdf_documents/standards_patient_care_and_transportation.pdf

Pre-Placement Health Form

Section A: Mandatory Medical Requirements

Student Name: ____ **Student 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:	( ) -	

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: Other Medical Requirements

Student Name: _____ **Student Number:** _____

Influenza

Instructions:

1. Applicable during the flu season (October to the end of April).
2. All students are required to receive an annual seasonal influenza immunization during flu season. Proof of flu vaccination must be submitted to Placement Pass for the date of the student's flu shot to be updated.
3. Students who have not received their flu vaccination during the flu season ***may be removed*** from clinical placement thereby jeopardizing successful completion of the clinical course. Placement partners require that students receive influenza immunization and show proof, especially if there is an outbreak.
4. 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.*

	Seasonal Dose
Date Vaccine Administered:	YYYY/MM/DD
Product Name:	
Provide Vaccine Record AND/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:** _____

Pre-Placement Health Form

Section B: Other Medical Requirements

Student Name: _____ **Student Number:** _____

COVID-19

Instructions:

1. Proof of vaccination for the primary COVID-19 vaccine series is mandatory. Students are required to submit documented proof of all COVID-19 vaccine doses received, including product name(s) and date(s) of vaccination. Booster doses are strongly recommended as these requirements are based on the placement organizations and their policies and subject to change.
2. 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:
    a. The medical reason they cannot be vaccinated for COVID-19, and
    b. 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.

		Dose 1	**Dose 2**
Full Series	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		
Booster Dose(s)	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 C: Mandatory Non-Medical Requirements

Student Name: _____ **Student Number:** _____

Instructions for Students:

1. As a student accepted in this program, you are required to complete the following non-medical requirements (see below).
2. Review your communication package to find out how and where to obtain these requirements.
3. Student to complete the Date of Issue and Expiry Date. Please ensure your requirements **have not expired** and remain **valid until the end of your academic year.**

Non-Medical Requirements	Date Issued	Expiry Date
CPR Level HCP or BLS Certificate (valid for 1 year)		
Standard First Aid Certificate (valid for 3 years)		
Vulnerable Sector Police Check (valid for 1 year) *Must be dated within 6 months of your placement start date		
N95 Mask Fit Testing (valid for 2 years)		
Half Mask Fit Test (valid for 2 years) – **due in Level 3** (in September)		
Class F License – **due in Level 3** (in September)		

Pre-Placement Health Form

Requirements Checklist

Student Name: _____ **Student Number:** _____

Section A – Medical Requirements	**Was Section A completed and signed by a physician? Include supporting documents.**
Tuberculosis (TB) Screening	☐
Measles Mumps and Rubella (MMR)	☐
Varicella (Chickenpox)	☐
Tetanus/Diphtheria (Td)	☐
Pertussis	☐
Polio	☐
Hepatitis B	☐
Reportable Communicable Diseases Statement	☐
Section B – Other Medical Requirements	**Do I have all the supporting documents?**
Influenza Immunization	☐
COVID-19 Immunization	☐
Section C – Non-Medical Requirements	**Do I have all the supporting documents?**
CPR Level HCP or BLS Certificate	☐
Standard First Aid	☐
Vulnerable Sector Check	☐
N95 Mask Fit Test Certificate	☐
Half Mask Fit Test Certificate (Level 3) – **due in September**	☐
Class F License (Level 3) – **due in September**	☐