

Program Name: Pembroke – Practical Nursing

Code (#): 1704X

Year: 2

Yearly Requirements to be uploaded by:

- Fall Start: **August 15th, 2024**
- Winter Start: **December 15th, 2024**

Required documents to remain valid until:

- Fall Start: **May 31, 2025**
- Winter Start: **September 30, 2025**

Student Instructions for Mandatory Requirements



- ▶ Verify that documents are clear and legible before submitting to the Placement Pass website.
- ▶ Access the Algonquin College Placement Pass website for the most current Pre-Placement Health Form Package: algonquincollege.placementpass.ca.

1. Review the requirements checklist below:

SECTION	REQUIREMENT	Ensure all requirements are complete with records and certificates included
Section A – Medical Requirements <i>(Completed and signed by Health Care Provider)</i>	Tuberculosis Screening	<input type="checkbox"/>
	Completion of temporary exceptions	<input type="checkbox"/>
	Influenza: Due Dec. 1st 2024	<input type="checkbox"/>
	COVID-19	<input type="checkbox"/>
Section B – Non- Medical Requirements	CPR Level C Certificate	<input type="checkbox"/>
	N95 Mask Fit Test Certificate	<input type="checkbox"/>
	WHMIS	<input type="checkbox"/>
	Vulnerable Sector Police Check	<input type="checkbox"/>

2. Book an appointment with a Physician, Nurse Practitioner, or Algonquin College Health Services.
3. 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.
4. Ensure that any requirements that were previously given a temporary exception are completed with vaccine records and lab results included.
5. Request a copy of your chest X-ray report from your health care provider if updated from last submission:
6. Complete **Section B**: Mandatory non-medical requirements
7. Complete checklist (above) to ensure all requirements are met for both sections (A & B):
 - a. Section A (both pages) completed, initialed, and signed by your Health Care Provider
 - b. For temporary exception completion- blood test reports and vaccine records
 - c. Chest X-ray report
 - d. Section B certificates or proof of completion for any non-medical requirement
8. Scan, label, and submit all documents to the Placement Pass website located at: algonquincollege.placementpass.ca

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.
3. Proof is required for completion of any vaccine series given a previous temporary exception such as polio, tetanus or hepatitis B. Updated vaccine records for dose #3 plus lab test result confirming immunity to Hepatitis B required.

*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.*
4. Use the following instructions when completing the following subsections:
 - a. **Tuberculosis Screening:**
 - i. Students who previously tested negative are required to have a repeat 1-step TB skin test. TB screening is valid for 1 year and the date is not to expire before completion of the academic year.
 - ii. If a student was positive from a previous 2-step skin test, a TB skin test is not required; instead, proceed to a chest X-ray.
 - iii. For any student who tested positive:
 1. Complete assessment and document on form if the student is clear of signs and symptoms of active TB. (This is an annual requirement).
 2. A chest X-ray is required (valid for 2 years).
 - b. **Influenza (Flu)**
 - i. Only applicable during flu season (October to the end of April)
 - ii. Influenza vaccine is strongly recommended for the indicated program.
 - iii. If a medical exemption to flu vaccination is indicated, the document must follow current NACI recommendations.
 - iv. **Note:** Student must sign the influenza waiver if they do not intend to get the seasonal flu shot (see page 2, Section A).
 - c. **COVID-19**
 - i. Proof of vaccination is required for each dose (including booster) of COVID-19 vaccine, or
 - 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).
 - ii. **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 page 2, Section A)
5. 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)

! 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 SCREENING	Date Administered	Date Read (48-72 hours from testing)	Results * (Induration in mm)
<i>If previously negative 1-Step Mantoux Test</i>			
1-step	YYYY/MM/DD	YYYY/MM/DD	_____ mm

*Chest X-ray results: Positive Negative N/A Date of Chest X-Ray: _____ YYYY/MM/DD
Signs/symptoms of active TB on physical exam? Yes No Health Care Provider Initials: _____

POLIO SERIES COMPLETION (if applicable)	Dose #3
Date Vaccine Administered:	YYYY/MM/DD

Initial primary series completed? Yes No If no, provide primary series 3 doses HCP Initials: _____

TETANUS/DIPHTHERIA (TD) SERIES COMPLETION (if applicable)	Dose #3
Date Vaccine Administered:	YYYY/MM/DD

Initial primary series completed? Yes No If no, provide primary series 3 doses HCP Initials: _____

HEPATITIS B SERIES COMPLETION (if applicable)	Booster/ dose #4	Dose #5	Dose #6
Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD
Product Name:			

Do lab test results one-month **post final dose** indicate “immune Hepatitis B”? Yes No N/A HCP Initials: _____

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: _____

Student Name: _____

Student ID: _____

COVID-19		Dose 1	Dose 2
Full Series <i>Provide vaccine record</i>	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		
Booster Dose(s) <i>Provide vaccine record</i>	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		
<p>COVID-19 Waiver: Booster doses are strongly recommended as these requirements are based on the placement organizations and their policies and subject to change.</p>		<p>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.</p> <p>Student Signature: _____</p>	

Health Care Provider Signature & Identification		Professional Identification Stamp:
Printed Name:		
Signature:		
Initials:		
Designation:	<input type="checkbox"/> MD <input type="checkbox"/> RN (EC) <input type="checkbox"/> RN/RPN <input type="checkbox"/> PA	
Phone Number:	() -	

Health Care Provider Signature & Identification		Professional Identification Stamp:
Printed Name:		
Signature:		
Initials:		
Designation:	<input type="checkbox"/> MD <input type="checkbox"/> RN (EC) <input type="checkbox"/> RN/RPN <input type="checkbox"/> PA	
Phone Number:	() -	

Pre-Placement Health Form

SECTION B: Mandatory Non-Medical Requirements

Student Name: _____

Student ID: _____

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!	<ul style="list-style-type: none"> ▶ 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 (see dates above). ▶ Submit supporting documents in PDF format, if possible. ▶ Please verify that documents are clear and legible before submitting to the Placement Pass website.
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NON-MEDICAL REQUIREMENTS

N95 Mask Fit Test Certificate: must be completed every 2 years.

WHMIS (Workplace Hazardous Materials Information System): must be completed every year.

CPR C Certificate: must be completed every year.

- ▶ Fall Semester Start: Must be dated after May 31st, 2024
- ▶ Winter Semester Start: Must be dated after September 30th, 2024

Vulnerable Sector Police Check: must be completed every year.

- ▶ Fall Semester Start: Must be dated after May 31st, 2024
- ▶ Winter Semester Start: Must be dated after September 30, 2024