

Student Name: \_\_\_\_\_

Student ID: \_\_\_\_\_

Program Details		
Occupational Therapy Assistant - Physiotherapy Assistant (Year 1)	1623X	<input type="checkbox"/>
Occupational Therapy Assistant - Physiotherapy Assistant (Year 2)	1623X	<input type="checkbox"/>

**Student Instructions for Mandatory Requirements**

- Review the requirements checklist below

SECTION	REQUIREMENT	Ensure all requirements are complete with records and certificates included	
<b>Section A – Medical Requirements</b> <i>(Completed and signed by Health Care Provider)</i>	<b>Year 1 &amp; 2</b>	Tuberculosis Screening	<input type="checkbox"/>
		Influenza	<input type="checkbox"/>
		Covid-19	<input type="checkbox"/>
	<b>Year 1</b>	Measles Mumps and Rubella (MMR)	<input type="checkbox"/>
		Varicella (Chicken Pox)	<input type="checkbox"/>
		Tetanus/Diphtheria (Td)	<input type="checkbox"/>
		Pertussis	<input type="checkbox"/>
		Polio	<input type="checkbox"/>
<b>Section B – Non-Medical Requirements</b>	<b>Year 1 &amp; 2</b>	Hepatitis B	<input type="checkbox"/>
		Standard First Aid	<input type="checkbox"/>
		CPR Level C	<input type="checkbox"/>
		Vulnerable Sector Check	<input type="checkbox"/>
		Workplace Health and Safety Awareness	<input type="checkbox"/>
	WHMIS	<input type="checkbox"/>	
<b>Year 2</b>	Mask Fit	<input type="checkbox"/>	

- Access the **Algonquin Placement Pass** website for the most current Pre-Placement Health Form: [algonquincollege.placementpass.ca](http://algonquincollege.placementpass.ca)
- Book an appointment with a Physician or Nurse Practitioner and bring vaccine records, public health forms or documents that show your immunization history to your appointment.
- Provide **Section A** (instructions and forms) to your health care provider to complete, initial, and sign/stamp.  
**Note:** *RNs/RPNs may also co-sign portions of the form.*
- Ensure your health care provider gives you the following documents to upload to Placement Pass with the health forms:
  - Vaccine records (with **name** on each record), including childhood immunization records if available.
  - Laboratory blood results
  - Chest X-ray report, if required.
- Complete **Section B**: Mandatory non-medical requirements and provide certificates or proof of completion for each requirement.
- Complete checklist (above) to ensure all requirements are met for both sections (A & B).
- Scan, label, and submit all documents at [Algonquincollege.placementpass.ca](http://Algonquincollege.placementpass.ca)
  - ▶ Students who started a vaccine series will receive a temporary exception after two doses. Once available, they will submit vaccine records and/or blood test results confirming completion.
  - ▶ Verify that documents are clear and legible prior to submission to the Placement Pass website.

# 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 vaccination records and laboratory results.  
*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 Screening:**
    - i. 2- step TB Mantoux skin test is required regardless of BCG history and should be given 1 to 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.
    - 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. Any student who had completed a negative 2 step TB test, complete 1-step only.
    - 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 of your program start, 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. Either records of 2 doses of MMR vaccine or a lab blood test showing full immunity is required. 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.
    - ii. 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.*
  - c. **Varicella (Chicken Pox):**
    - i. Either records of 2 doses of varicella vaccine or a lab blood test showing evidence of full immunity is required.  
***Note:** This vaccine is not recommended (contraindicated) when pregnant. Pregnancy should be avoided for three months after a Varicella vaccination has been given.*
  - d. **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.

## Pre-Placement Health Form Health Care Provider Instructions

### e. 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 Tdap.
- iii. **Note:** *National Advisory Commission on Immunization (NACI) 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.*

### f. Hepatitis B:

- i. If previously immunized, a lab test must be obtained for evidence of immunity (antigen/antibody). 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 continue < 10 IU/L, continue with the vaccine series until completed, to be followed by another lab test 1 month after (\*may receive up to 6 doses).

### g. Influenza (Flu)

- i. Influenza vaccine is mandatory for the indicated program.
- ii. Only applicable during flu season (October to April)
- iii. If a medical exemption is indicated, the document must follow NACI recommendations.  
**Note:** *Student must sign the influenza waiver if they do not intend to get the seasonal flu shot (see page 2, Section A).*

### h. COVID-19

- i. Proof of vaccination is required for 2 doses (booster highly recommended) of COVID-19 vaccine, or
- ii. A medical note is required if a medical exemption to Covid-19 vaccination is indicated. This should follow current NACI recommendations and guidelines for a physician requested medical exemption of Covid-19 immunization. It must include:
  - medical reason they cannot be vaccinated for COVID-19, and
  - effective duration of time 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 page 2, Section A)*

### 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 SCREENING	Date Administered	Date Read (48-72 hours from testing)	Results * (Induration in mm)
<b>Initial 2-Step Mantoux Test – mandatory</b>			
1-step	YYYY/MM/DD	YYYY/MM/DD	_____ mm
2-step (7-28 days after one-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 (attach report): YYYY/MM/DD

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

**Note: S/S assessment must be renewed annually, and chest x-ray every two years** Health Care Provider Initials:  

MEASLES MUMPS AND RUBELLA (MMR)	Dose 1	Dose 2
Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD

Immune to MMR (attach serology report if applicable)?  Yes  No HCP Initials:  

VARICELLA (CHICKEN POX)	Dose 1	Dose 2
Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD

Immune to Varicella? (attach serology report if applicable)?  Yes  No HCP Initials:  

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

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

Received one dose of **Tdap** after 18<sup>th</sup> birthday?  Yes  No Product Name: \_\_\_\_\_ HCP Initials:  

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

Immune to Hepatitis B (attach serology report)?  Yes  No

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



## Pre-Placement Health Form

### SECTION A: Health Care Provider Form

INFLUENZA (FLU) - mandatory	Seasonal Dose
Date Vaccine Administered:	YYYY/MM/DD
Product Name:	
Health Care Provider Initials: <span style="border: 1px solid black; border-radius: 50%; padding: 2px 10px;"> </span>	

COVID-19 – primary series mandatory		Dose 1	Dose 2
<b>Full Series</b> <i>Provide vaccine record</i>	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		
<b>Booster Dose(s)</b> <i>Provide vaccine record</i>	Date Vaccine Administered:	YYYY/MM/DD	YYYY/MM/DD
	Product Name:		
<p><b>COVID-19 Waiver:</b> 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 placement due to placement organization requirements, thereby jeopardizing successful completion of the program.</p> <p><b>Student Signature:</b> _____</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 Details

Student Name: \_\_\_\_\_ Student ID (#): \_\_\_\_\_

Program Name: \_\_\_\_\_ Code (#): \_\_\_\_\_

- ▶ Review your communication from your program to find out when to obtain these requirements including **date to apply** and any other special instructions.
- ▶ Police record check and vulnerable sector criminal record check **date of issue** is required to be **within 6 months of your submission to Placement Pass**.
- ▶ 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

Year 1 & 2	Standard First Aid (valid for 3 years)
	CPR Level C (valid for 1 year)
	Vulnerable Sector Check (valid for 1 year)
	WHMIS (valid for 1 year)
	Workplace Health and Safety Awareness (no expiry)
Year 2	Mask Fit (valid for 2 years)