Fleming College

Mandatory Pre-Entry Requirement

IMPORTANT INSTRUCTIONS TO STUDENTS:

Completing the attached **Entry Immunization Form** is **mandatory pre entry requirement** for the program you are enrolled in.

It is imperative that you begin this process **immediately** as it can take several weeks to complete. Forms must be completed in full and **submitted to the College prior to starting school**. If you are an international student, the process needs to be completed in your home country.

Important Note: If you are a "returning" student, please call Student Health Services, 705-749-5504 before beginning the process, as completing the form and/or repeating blood work/other testing may not be necessary.

****NOTE****

You are responsible for completing the immunization requirements through your own health care provider and not Fleming College Student Health Services.

HEALTH SERVICES IS HERE TO HELP:
Health Services' staff will be pleased to answer any questions you have about completing this process. When you have submitted your form, staff will review your form and identify any incomplete sections to you. This will allow you the opportunity to re-submit your form with the completed information.

Fleming College

IMPORTANT INSTRUCTIONS

TO COMPLETING ENTRY IMMUNIZATION RECORD

Please read and follow each step below very carefully:

1. Before calling your healthcare provider, be sure that **you** have read through the entire **Entry Immunization Form**, so that **you** understand what is required.

2. Next, call your healthcare provider to book an appointment to get the required blood work done (your form will identify what blood work is needed). Most students will also require TB testing (see form for direction). For early childhood immunization records, you may need to contact your local Public Health Unit.

3. Once bloodwork has been completed, be sure your healthcare provider follows up with you (or you with them) regarding your results and provides any booster injections, as needed.

4. Copies of all bloodwork results, injection dates, chest x-ray results (if required) **must be recorded on and attached to the form.** Be sure to **"sign and date"** your form. (Located at the very bottom of the form (backside).

5. Do **not** submit your form until **all required sections are complete.** If your doctor is submitting the form on your behalf, it is imperative that you review the form prior to sending ensuring that all sections are complete. If we receive an "incomplete" form from your doctor, it is **your** responsibility for completeness, not your doctor.

6. Mail or fax, (see address and fax number below) to Health Services. Once the college is open, you can drop forms off in person to Health Services (Room A2113). **Be sure to keep a copy of all forms sent for your records.** Health Services does not keep a copy of your immunization form.

'If you are unable to participate in immunizations due to a "medical contraindication(s)", please contact your Program Coordinator ASAP, as obtaining a placement may not be possible due to strict regulations of certain agencies. Failure to participate in placement may also prevent you from meeting the necessary requirements of your program.

Please call us anytime with questions or assistance you may require in completing this process. Thank you.

Health Services, Fleming College
599 Brealey Drive, Room A2113, Peterborough, ON K9J 7B1
Phone: 705-749-5557
Fax: 705-749-5532

Fleming College

Do **NOT** submit your form until **all required sections** are complete. Forms must be submitted to Health Services.

Last Name: _____ Given Name(s):_____Program: _____

Date of Birth : _____ Student #: _____

Admission Date:_____ Phone #: _____ Fleming Email:_____

Tuberculosis Screening (TB)– Mandatory

(if previous positive skin test, then documentation of positive skin test along with most recent chest x-ray result needs to be recorded & attached to form.)

After receiving your first injection, injection #2 must be administered **7 to 28 days** after step 1. Results must be measured in mm. If two injections have been administered previously, following the above protocol, simply record dates below (repeating both injections is **not** required).

Date: Step #1 (dd/mm/yyyy)	Date Read: (dd/mm/yyyy)	Results in mm:
Date: Step #2 (dd/mm/yyyy) (7 – 28 days apart)	Date Read: (dd/mm/yyyy)	Results in mm:
If Mantoux Test is Positive: Chest x-ray required Date of x-ray: (dd/mm/yyyy)	Chest x-ray Result: **(Please attach chest x-ray result)**	
Did the student receive prophylactic treatment (INH?) ❑ Yes ❑ No	Has the student had a BCG vaccination? ❑ Yes ❑ No	
Any current signs and symptoms of active TB? ❑ Yes ❑ No		

Important Note Regarding TB Testing Only: **Identified programs listed below will be required to have an additional Annual Tuberculosis (TB) Single Injection if the dates of previous Skin tests (above) are greater than 12 months.**

-Practical Nursing -Pharmacy Technician -Developmental Service Worker -Fitness & Health
-Personal Support Worker -Child and Youth Care -Massage Therapy -Recreation & Leisure Services
-Health Information Management -Social Service Worker -Therapeutic Recreation -Social Service Worker/MHA (dual)
-Occupational Therapist/Physiotherapist Assistant -Community Pharmacy Assistant -Paramedic

Annual Tuberculosis (TB) Single Injection

Date: (dd/mm/yyyy)	Date Read: (dd/mm/yyyy)	Results in mm:

Tuberculosis Screening

1. All student must have **documented proof** of a Two-Step TB Mantoux skin test. If proof is not available for the Two-Step Mantoux skin test or if it has not been completed previously, then the student must receive an initial Two-Step TB Mantoux test. The Two-Step needs to be performed ONCE only and it never needs to be repeated again. Any subsequent TB skin tests can be One-Step, regardless of how long it has been since the last skin test. Students who have a received a BCG vaccination are NOT EXEMPT from the initial Mantoux testing. Pregnancy is NOT a contraindication for performance of a Mantoux skin test.
2. Mantoux testing must be completed prior to the administration of any live vaccines (ie MMR, IPV) OR **defer skin testing for 30 days** after the live vaccine is given.
3. If a student was positive from a previous Mantoux Two-Step skin test and/or has received TB treatment, the health care provider must provide a document stating the student is free from signs and symptoms of active tuberculosis.
4. Any student who has proof of a previous **negative** Two-Step, must complete a One-Step.
5. For any student who tests positive for the first time:
   a. Include results from the positive Mantoux screening (mm of induration).
   b. A chest x-ray is required and the report must be attached.
   c. Indicate any treatments that have been started.
   d. Provide documentation that the student is clear of signs and symptoms of active TB.
   e. The responsibility for follow up lies with the health care provider as per the OHA/OMA Communicable Disease Surveillance Protocols.

Red Measles, Mumps, Rubella (German Measles) – MMR – Mandatory (All Programs)

Documentation of receiving **two doses** of **MMR** on or after 1st birthday is required. If documentation is unavailable or if only one injection date is recorded, then **bloodwork must be done within the past six months of starting school to check immunity.** Blood tests must cover **measles, mumps and rubella.** Based on bloodwork results, further injection(s) may be required. See below for instruction. **Record & attach copy of bloodwork results to form.**

MMR Vaccinations: MMR #1 Date: (dd/mm/yyyy)_____ → MMR #2 Date: (dd/mm/yyyy)	If **two MMR dates are provided,** then **no further action is** required. If **no dates** provided or only **one MMR date recorded,** then **bloodwork is required.**
Bloodwork Date: (dd/mm/yyyy)_____ Measles Result:_____ Mumps Result:_____ } No immunity Rubella Result:_____ → Partial immunity ↓	If bloodwork results for all three viruses indicate **"non-reactive," "non-immune" or "indeterminate,"** then **two (2) MMR vaccines MUST be administered (4 weeks apart).** MMR #1 Date:(dd/mm/yyyy)_____ MMR #2 Date:(dd/mm/yyyy)_____
If bloodwork results for **one or two of the viruses** above indicate **"non-reactive", "non-immune" or "indeterminate,"** then **one (1) single booster dose of MMR is required.** →	**MMR Booster Date:**(dd/mm/yyyy)_____

Varicella (Chicken Pox or Shingles) – Mandatory (All Programs)

Documented two (2) doses of receiving vaccination **or** bloodwork results showing immunity are required. Bloodwork results for **Varicella only** are not date specific and we will accept any bloodwork done in the past**.**
Record and attach copy of bloodwork results to form.

*Dose # 1: (dd/mm/yyyy) **OR**	**Varicella Bloodwork Date:** (dd/mm/yyyy)
*Dose # 2: (dd/mm/yyyy)	Bloodwork Result:
	***Two injections required only if bloodwork results above indicate **"non-reactive," "non-immune" or "indeterminate."**

Diphtheria/Tetanus/Acellular Pertussis/Polio (DTaP – IPV)
Childhood Series and Current Booster – Mandatory all programs

Documentation of completed childhood series is required **(approx. ages 2 months to 5 years).** Record of most recent booster of Td or Tdap in the **last 10 years** is also required. These records can be obtained from a yellow immunization card or by contacting the local Public Health Unit or your family physician.

Note: In addition to recording your childhood series date (below), students in programs who will be attending placement within a hospital setting, i.e. **Practical Nursing, Personal Support Worker, Pharmacy Technician, Community Pharmacy Assistant, Health Information Management, Occupational Therapist Assistant/Physiotherapist Assistant** should ensure that they have received a minimum of **one (1)Tdap (Adacel/Boostrix) booster dose,** to satisfy the pertussis surveillance protocol for Ontario hospitals, as per OHA/OMA guidelines.

Childhood Series (doses 1 – 5 below)
Dose # 1: (dd/mm/yyyy)
Dose # 2: (dd/mm/yyyy)
Dose # 3: (dd/mm/yyyy)
Dose # 4: (dd/mm/yyyy)
Dose # 5: (dd/mm/yyyy)
Td Booster:dd/mm/yyyy_____ AND/OR Tdap Booster: dd/mm/yyyy_____ Required every 10 years
Important Note: If childhood series dates above are "unavailable" or if records are "incomplete", then **"un-immunized adult series"** must be given for **Tetanus & Polio.** Please discuss this with your health care provider, or call Student Health Services for further clarification, if needed.

Hepatitis B Bloodwork – Mandatory only for programs below:

Note Underlined programs will be required to have repeat Hepatitis B bloodwork after booster or series. More info in table below.

-Practical Nursing
-Personal Support Worker
-Health Information Management
-Pharmacy Technician
-Community Pharmacy Assistant
-Child and Youth Care
-Occupational Therapist/Physiotherapist Assistant
-Massage Therapy
-Developmental Service Worker
-Paramedic

Must have Hepatitis B bloodwork immunity testing **done within the past six months of starting school.** Documentation of Hepatitis B vaccinations for these programs is also required. For all other programs, Hepatitis B vaccinations are not mandatory, but strongly recommended**. Record and attach copy of bloodwork results to form.**

Date of Hepatitis B Vaccine	**Dose #1**	**Dose #2**	**Dose #3**
Hepatitis B Bloodwork (HbsAb)	**Date of Bloodwork:**	**Bloodwork Result**	**Please attach copy of the result**
Hepatitis B Booster Dose Required if bloodwork result is < 10 iu/ml	**Date:**		
Repeat Hepatitis B Bloodwork (required only if hepatitis B booster or series was given) Bloodwork must be done at least one month after the booster.	**Date of Bloodwork:**	**Bloodwork Result:**	**Please attach copy of result**

RELEASE OF INFORMATION	
By signing below, I certify all information to be true and correct to the best of my knowledge. My signature also permits release of these forms and any supporting documentation to the School Office Designate(s) who may also share this information with a placement agency for purposes of securing a placement for me. Failure to complete this form and provide the required documentation may prevent you from obtaining a placement due to the strict regulations of certain agencies. This form **is not** retained by Health Services, so be sure to **keep a copy for your own personal records**.	
Student Signature:	**Date:**

***Are you a paramedic student? Yes_____No_____ If yes, please see below.**

Physician: I have reviewed this patient's records and acknowledge and confirm that they have been immunized against each of the diseases set out in this form as per Table 1– Part A of the Ambulance Service Communicable Disease Standards (Version 2.0)

Physician Signature:	**Date:**

Fleming College

Student #_____

Pre-Service fire fighter education & training students
pre-entry health clearance form

Please Print Date of Exmination_____

Patient's Last Name:	First Name:	Middle Name:
Street Address:	City:	Postal Code:

HEALTH HISTORY

To be completed by examining physician. **YES** answers should be explained on question 11.

History Details & Summary	Yes	No
1. Diseases of Senses (Deafness, Vertigo, Visual Deficiencies, etc.	☐	☐
2. Cardiovascular Diseases (Heart Failure, Angina, Infarction, Embolism, Arrhythmia, Syncope, Surgery, etc.)	☐	☐
3. Respiratory Diseases (Asthma, Chronic Bronchitis, Emphysema, etc.)	☐	☐
4. Diseases of the Musculo-Skeletal System (Fracture(s) or Amputation, Arthritis, etc.)	☐	☐
5. Metabolic Diseases (Diabetes (+)(-), Hypoglycemia, Thyroid, etc.)	☐	☐
6. Psychiatric Disorders (Psychoneurosis, Psychosis, etc.)	☐	☐
7. Addictions (Alcohol, Sedatives, Tranquilizers, Narcotics, etc.)	☐	☐
8. Other Diseases (Blackouts, Fainting Spells, Anemia, Cancer, Blood Dyscrasia, etc.)	☐	☐
9. Neurological Diseases (Seizures, Cerebrovascular Diseases, Parkinson's Disease, Multiple Sclerosis, Dementia, Head Injury, Mental Retardation, etc.	☐	☐

Date of First Seizure _____ Date of Last Seizure _____

MEDICAL EXAMINATION

Height _____ Weight_____

1. Eyes

	Acuity Without Glasses	Acuity With Glasses	Horizontal Field of Vision
Right	20/_____	20/_____	Normal ☐ Restricted ☐
Left	20/_____	20/_____	Normal ☐ Restricted ☐
Both eyes together	20/_____	20/_____	Normal ☐ Restricted ☐

Colour blindness Yes ☐ No ☐

Squint, disease or eye injury_____

Indicate type of tests given Snellen ☐
Other_____

2. Hearing Meets standards defined in the H.T.A. with or without a hearing aid. Yes ☐ No ☐
3. Heart Apical Rate_____ Rhythm_____ Murmurs_____
   B.P._____/_____
4. Locomotor Upper Extremity_____ Lower Extremity_____ Neck and Lumbar_____
5. Chest/Abdomen_____
   _____
6. Urinary Urine Protein_____ Glucose_____
7. Diabetes Yes ☐ No ☐ Type_____
   Treatment Diet Alone ☐ Oral Medication (amt. per 24 hrs.) ☐_____Insulin (amt. per 24 hrs.) ☐_____

8. Hypoglycemia Frequency_____
Circumstances_____
Loss of Consciousness_____Decrease in Cognition etc._____

9. Neurological Gait and Stance_____
Reflexes_____
Tremor_____Coordination_____

10. Mental
Competence_____Judgement_____

Evidence of Emotional Disorder

Instability Yes ☐ No ☐ Psychosis Yes ☐ No ☐ Drug Habituation Yes ☐ No ☐
Neurosis Yes ☐ No ☐ Alcoholism Yes ☐ No ☐

11. History Details and Summary (including details of all medication prescribed and dosage, degree of decompensation in cardiovascular diseases.)

How long has this person been your patient?_____ Family Physician ☐ or Certified Specialist in_____

Physician's

Name_____Signature_____Date_____