**Clinical Preparedness Permit** 2018

Student Last Name: _____ Student First Name: _____

Seneca College Student Number: _____ Seneca College Student E-Mail: _____

York Student Number: _____ York Student E-Mail: _____

Students are required to:

1. Read the guideline document that accompanies this permit carefully for details related to all of the components of the clinical preparedness permit.
2. Have an authorized health care provider sign-off and provide the appropriate lab report(s) to support the immunization record.
3. Present this permit and original documents for verification stamping each term. The student will not enter clinical placement unless the permit is stamped.
4. Bring the stamped permit on the first day of the clinical placement site.
5. Make sure the permit or copy is available to present if requested at the clinical placement site.
6. It is the responsibility of the student to keep this form and associated documents current and up to date for placement purposes.
7. **Important: make a photocopy of this permit after each update and store in a safe place.**

| Requirement | Page | Page in Guide | Upon Entry | Every Year | Every 2 Years |
|---|---|---|---|---|---|
| Vulnerable Sector Police | 4 | 2/3 | X | X | |
| CPR-HCP | 5 | 3 | X | X | |
| Standard First Aid | 5 | 3 | X | | |
| Respirator Mask Fit | 5 | 4 | X | | X |
| Worker Health and Safety Awareness Certificate and WHMIS Certificate | 5 | 4/5 | X | | |
| Base-line Two Step OR One-Step Mantoux Skin Test | 2 | 5 | X | | |
| One Step Mantoux Skin Test | 2 | 5 | | X | |
| Immunizations & Titres | 2/3 | 5/6/7 | X | | |
| Flu Vaccination (In October/November) | 4 | 7 | | X | |

Student Last Name: _____ Student First Name: _____

Medical Requirements (to be completed by Health Care Provider)

**Mandatory Lab Reports (to be completed by Health Care Provider)**

**TB Mantoux Skin Test**

| Mantoux Skin Test | Date Given | Date Read (48h-72h from testing) | Induration (mm) |
|---|---|---|---|
| **Baseline 2 Step 1** | | | |
| **Step 2 (7-28 days after Step 1)** | | | |
| Step 1 | | | |
| Step 1 | | | |
| Step 1 | | | |
| Step 1 | | | |
| Step 1 | | | |

Chest x-ray- Date & Result _____

Chest x-ray- Date & Result _____

Health Care Providers letter (if applicable) attached

Health Care Providers letter (if applicable) attached

Health Care Provider Signature: _____

**MMR (Measles, Mumps, Rubella) and Varicella (Chicken Pox).**

Students are required to have their Health Care Provider complete the below section and keep hard copies of lab results with this package at all times.

| | Immunity |
|---|---|
| Measles | ☐ Yes ☐ No ☐ Indeterminate |
| Mumps | ☐ Yes ☐ No ☐ Indeterminate |
| Rubella | ☐ Yes ☐ No ☐ Indeterminate |
| Varicella | ☐ Yes ☐ No ☐ Indeterminate |

If lab results show no or indeterminate immunity for any of the above, a booster is required and no further titres are required.

| Booster | Date Given |
|---|---|
| MMR | |
| Varicella | |

Health Care Provider Signature: _____

Student Last Name: _____ Student First Name: _____

**Polio**

Date Primary Series Completed:

**OR**

Date of Last Booster (if required):

Health Care Provider Signature:

**Tetanus/Diphtheria (TD)/Pertussis**

Date of Last Tetanus:

Date Primary Series Completed:

Date of Booster:

Optional: Adacel (1 dose)
Date Given:

Health Care Provider Signature:

**Hepatitis B**

| | |
|---|---|
| 1st Vaccination Date: | |
| 2nd Vaccination Date (within 1 month of the 1st) | |
| 3rd Vaccination Date (6 months after the 1st) | |

Lab reports (titers) Results

| | |
|---|---|
| Immune: | ☐ Yes ☐ No ☐ Indeterminate |

Health Care Provider Signature:

**Hepatitis B**
**Negative or Indeterminate Immunity Result**

Students may enter clinical placements as long as they have had their 2nd Hep. B vaccine.

For non-responders, additional doses, up to another complete series of three, can be done, with testing for response after each dose.

If applicable
Start date of second series:

After Having received the series of Hepatitis vaccine and having post-vaccination blood work the student still does not show immunity and is a non-responder.

Health Care Provider Signature:

Student Last Name: _____ Student First Name: _____

**Influenza Vaccination (Flu Shot)**

**ANNUAL IMMUNIZATION VACCINE ONLY AVAILABLE DURING FLU SEASON (OCTOBER/NOVEMBER).**

Students who have not received the vaccination will be removed from clinical placement. **In the event of an outbreak at your placement, *any student without the vaccination may be denied access* to the facility thereby jeopardizing successful completion of the clinical course.**

| Year of Program | Date Received | Health Care Provider Signature |
|---|---|---|
| 1st Year | | |
| 2nd Year | | |
| 3rd Year | | |
| 4th Year | | |

## Non-Medical Requirements

**Vulnerable Sector Screening (VSS) Police Record Checks (Required Annually or every 6 months dependant on clinical agency)**

Students are required to complete the below section and keep hard copy of the certificate with this permit at all times.

| Police Check Service (Police Region) | Date of Issue |
|---|---|
| | |
| | |
| | |
| | |
| | |

Student Last Name: _____ Student First Name: _____

## CPR at the Health Care Provider Level (CPR-HCP)

Students are required to complete the below sections, and keep hard copy of the certificate with this package at all times.

| Company | Date of Issue |
|---|---|
| | |
| | |
| | |
| | |

## Standard First Aid

Only required for collaborative students upon entry.

| Company | Date of Issue |
|---|---|
| | |

## Respirator Mask Fit Testing (Completed Every two Years)

| | |
|---|---|
| Date of Issue Upon Entry to Program at Seneca | |
| Date of Issue Upon Entry to York | |

## Ministry of Labour's Worker Health and Safety Awareness Certification (Completed Every Two Years)

Students are required to complete the below section and keep the hard copy with this permit at all times.

| | |
|---|---|
| Date of Issue Upon Entry to Program at Seneca | |
| Date of Issue Upon Entry to York | |

## WHMIS (Completed Every Two Years)

| | |
|---|---|
| Date of Issue Upon Entry to Program at Seneca | |
| Date of Issue Upon Entry to York | |

Student Last Name: _____ Student First Name: _____

***This page is for the Practicum "verification" stamp***. *This means that the appropriate staff person/agency has verified that the required clinical documents and information is current and clear and up to date as per clinical guidelines/requirements.*

| | | | |
|---|---|---|---|
| Proceed to: _____<br>Approved by: _____<br>Date: _____<br>Verification of Clearance | Proceed to: _____<br>Approved by: _____<br>Date: _____<br>Verification of Clearance | Proceed to: _____<br>Approved by: _____<br>Date: _____<br>Verification of Clearance | Proceed to: _____<br>Approved by: _____<br>Date: _____<br>Verification of Clearance |
| Proceed to: _____<br>Approved by: _____<br>Date: _____<br>Verification of Clearance | Proceed to: _____<br>Approved by: _____<br>Date: _____<br>Verification of Clearance | Proceed to: _____<br>Approved by: _____<br>Date: _____<br>Verification of Clearance | Proceed to: _____<br>Approved by: _____<br>Date: _____<br>Verification of Clearance |

Student Last Name: _____ Student First Name: _____

**TO BE COMPLETED BY HEALTH CARE PROVIDER (HCP)**

| | |
|---|---|
| Name: | *(please print)* |
| Address: | |
| Official HCP Stamp: | |
| Telephone: | |
| Signature: | |
| Date: | |

| | |
|---|---|
| Name: | *(please print)* |
| Address: | |
| Official HCP Stamp: | |
| Telephone: | |
| Signature: | |
| Date: | |