

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				MMR (Measles, Mumps, Rubella) and Varicella (Chicken Pox).											
Mantoux Skin Test	Date Given	Date Read (48h-72h from testing)	Induration (mm)	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.											
Baseline 2 Step 1				<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 50%;">Immunity</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">Measles</td> <td style="padding: 5px;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate</td> </tr> <tr> <td style="padding: 5px;">Mumps</td> <td style="padding: 5px;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate</td> </tr> <tr> <td style="padding: 5px;">Rubella</td> <td style="padding: 5px;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate</td> </tr> <tr> <td style="padding: 5px;">Varicella</td> <td style="padding: 5px;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate</td> </tr> </tbody> </table>			Immunity	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate	Rubella	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate	Varicella	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate
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Step 2 (7-28 days after Step 1)				If lab results show no or indeterminate immunity for any of the above, a booster is required and no further titres are required.											
Step 1				<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Booster</th> <th style="width: 70%;">Date Given</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">MMR</td> <td></td> </tr> <tr> <td style="padding: 5px;">Varicella</td> <td></td> </tr> </tbody> </table>		Booster	Date Given	MMR		Varicella					
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Varicella															
Step 1															
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Chest x-ray- Date & Result _____															
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Health Care Providers letter (if applicable) attached															
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 Health Care Provider Signature: _____				 Health Care Provider Signature: _____											

Student Last Name: _____

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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

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

Lab reports (titers) Results

Immune:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Indeterminate
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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
1 st Year		
2 nd Year		
3 rd Year		
4 th 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.





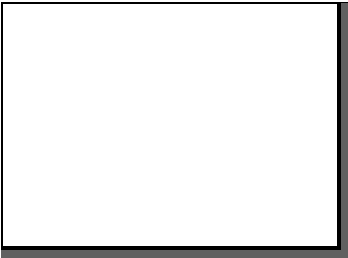
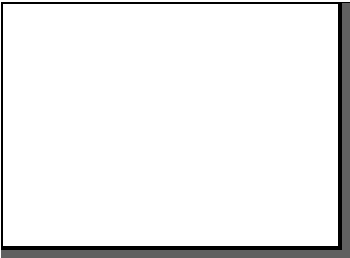
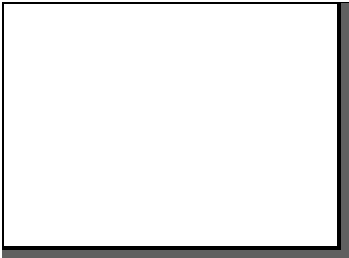
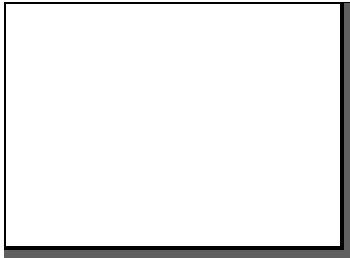
Date of Issue Upon Entry to Program at Seneca	
Date of Issue Upon Entry to York	

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.

<p>Proceed to: _____</p> <p>Approved by: _____</p> <p>Date: _____</p> <p>Verification of Clearance</p> 	<p>Proceed to: _____</p> <p>Approved by: _____</p> <p>Date: _____</p> <p>Verification of Clearance</p> 	<p>Proceed to: _____</p> <p>Approved by: _____</p> <p>Date: _____</p> <p>Verification of Clearance</p> 	<p>Proceed to: _____</p> <p>Approved by: _____</p> <p>Date: _____</p> <p>Verification of Clearance</p> 
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Student Last Name: _____ Student First Name: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER (HCP)

Name:	
	<i>(please print)</i>
Address:	
Official HCP Stamp:	
Telephone:	
Signature:	
Date:	

Name:	
	<i>(please print)</i>
Address:	
Official HCP Stamp:	
Telephone:	
Signature:	
Date:	