MEDICAL REPORT

COMPLETED WITHIN 45 DAYS OF COMMENCEMENT OF STUDY

GENERAL

The Communicable Disease Protocols require that hospitals and community placements must have documented proof of immunization and/or history of specific communicable disease for all persons. Please provide actual dates for requested immunizations listed below.

Section 1: To be Completed by the Student

Name: _____ Student No: _____

Program: _____ Start Date: _____/_____

Address: _____ City: _____

Province: _____ Postal Code: _____ Date of Birth: _____/_____/_____

Home/Cell Phone: _____ DD/MM/YY

The information given below is true to the best of my knowledge and I authorize the release of the information to any college placement.

Signature: _____ Date: _____

Section 2: To be Completed by Health Professional (required)

2.1 TUBERCULOSIS: Documentation of a two-step tuberculin skin test is required regardless of BCG vaccination.

An initial tuberculin skin test is given **and must be read between 48 and 72 hours in mm of induration** after the skin test is given. If this test is 0-9mm of induration, a second test is given in the opposite arm **at least one week and no more than four weeks after** the first TB test and **must be read between 48 and 72 hours later and recorded in mm induration**.

If it has been **more** than 12 months since the two-step TB test, a one-step TB skin test is also required, and **dates of the previous two step are required**. Please do not receive any Covid-19 vaccine until your TB skin testing is complete. If you have recently received a **Covid-19 vaccine**, please wait 28 days from the date of administration to start the TB skin testing process. This 28-day waiting period is required as a **Covid-19 vaccine** can alter the results of the TB skin test.

NOTE: If the student has previously tested Positive (10mm or greater) please enter the following:

Date of Positive Test: _____ Result: _____mm induration Physician signature: _____
DD/MM/YYYY

TUBERCULIN SKIN TESTING: **TWO-STEP MUST BE COMPLETED / RESULTS MUST BE RECORDED IN mm INDURATION**.

Step 1: Date Given: _____ Given By: _____
DD/MM/YYYY

Date Read: _____ Read By: _____ Result: _____ mm induration
DD/MM/YYYY

Step 2: Date Given: _____ Given By: _____
DD/MM/YYYY

Date Read: _____ Read By: _____ Result: _____ mm induration
DD/MM/YYYY

If it has been more than 12 months since the two-step TB test (recorded above), A ONE-STEP TB UPDATE TEST IS ALSO REQUIRED.

Update: Date Given: _____ Given By: _____
DD/MM/YYYY

Date Read: _____ Read By: _____ Result: _____mm induration
DD/MM/YYYY

NOTE: Persons who are tuberculin positive (10mm or greater) must have a chest x-ray completed.

Date of Chest X-Ray: _____ Result: _____ Physician/NP Signature: _____

Name: _____ Student No: _____

Section 2 (Cont'd): To be Completed by Health Professional (required)

2.2 MEASLES, MUMPS, RUBELLA (MMR): Proof of Measles, Mumps, Rubella immunity is required. Only the following will be accepted:

Option 1: A documented history **(vaccination record must be attached)** of two doses of MMR

Date of **first** MMR: _____
DD/MM/YY

Date of **second** MMR: _____
DD/MM/YY

Date of **booster** (if required): _____ Physician Signature: _____
DD/MM/YY

**Do not give MMR vaccine until after TB skin testing is completed. MMR may be given at the same time as Varicella vaccine or give MMR and Varicella vaccines at least 4 weeks apart. Healthy adults 18 years of age and older, MMRV is not authorized for use in the age group as per NACI guidelines. (National Advisor Committee in Immunization).*

Option 2: Laboratory evidence showing immunity to Measles, Mumps and Rubella

Blood work dates:

Measles Immunity: _____ Mumps Immunity: _____ Rubella Immunity: _____
DD/MM/YY DD/MM/YY DD/MM/YY

2.3 VARICELLA IMMUNITY: Proof of Varicella (chicken pox) immunity is required. Only the following will be accepted:

Option 1: Laboratory evidence showing immunity to Varicella

Blood work date: Varicella Immunity: _____
DD/MM/YY

Option 2: A documented history (vaccination record must be attached) of two doses of Varicella vaccine. A minimum of 4-week interval is required between doses, NACI recommends 6-12-week interval between doses.

Date of **first** Varicella: _____ Date of **second** Varicella: _____ Physician Signature: _____
DD/MM/YY DD/MM/YY

**Do not give Varicella vaccine until after TB skin testing is completed. Varicella may be given at the same time as MMR vaccine or Varicella and MMR vaccines at least 4 weeks apart. Healthy adults 18 years of age & older, MMRV is not authorized for use in this age group as per NACI guidelines. (National Advisory Committee on Immunization).*

2.4 TETANUS DIPHTHERIA & PERTUSSIS:

Date within the last 10 years: _____ **Vaccination record must be attached.**

**Adult Health Care workers regardless of age, should receive a single dose of tetanus diphtheria acellular pertussis vaccine (Tdap) for pertussis protection if not previously received in adulthood. The adult dose is in addition to the routine adolescent booster dose. Ontario Hospital Association, 2017.*

2.5 HEPATITIS B VACCINE: Proof of Hepatitis B immunity is REQUIRED for Early Childhood Education and Personal Support Worker Programs. All other programs are strongly recommended to complete Hepatitis B Vaccine Series. Only the following will be accepted:

Option 1: A documented history **(vaccination record must be attached)** of vaccination series (2 or 3 doses)

Date of **first** Dose: _____ Date of **second** Dose: _____ Date of **third** Dose: _____
DD/MM/YY DD/MM/YY DD/MM/YY

Date of **booster** (if required): _____ Physician Signature: _____
DD/MM/YY

Option 2: Laboratory evidence showing immunity to Hepatitis B

Blood work date: _____ Titre Results: _____
DD/MM/YY DD/MM/YY

Name: _____ Student No: _____

2.6 COVID-19 VACCINE: Proof of COVOD-19 vaccination is required.

If you are unvaccinated, **a letter stating medical reason is required**. Medical exemption requests will be reviewed by the Director, Student Services. on a case-by-case basis and may result in longer clearance times.

Date of **first** Dose: _____ Name of Vaccine: _____
DD/MM/YY

Date of **second** Dose: _____ Name of Vaccine: _____
DD/MM/YY

Date of **third** Dose (if applicable): _____ Name of Vaccine: _____
DD/MM/YY

*__Evidence of COVID-19 vaccine must be included along with this form__. Attached is a link regarding Guidance for Individuals vaccinated outside of Ontario/Canada.

https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19_guidance_for_individuals_vaccinated_outside_of_ontario.pdf

Section 3: To be Completed by Physician (required)

Check List of Essential Physical Abilities

Physical Demand	Sample Duties	Demonstrated	
		Yes	No
Lifting (up to 25 kg)	Laundry, groceries, use of equipment (lifts, vacuum)	❒	❒
Carrying and shifting weight (up to 25 kg)	Client transfers and positioning, assisting with personal care, groceries, laundry	❒	❒
Push/Pull (up to 25kg)		❒	❒
Handling, gripping, feeling		❒	❒
Mobility Limbs/back Bending Crouching Kneeling Balancing Sitting Standing (possibly for long periods) Climbing stairs (leg and knee flexibility) Pushing and pulling Reaching Hand/arm and shoulder dexterity	Housekeeping duties Client transfers and repositioning Assisting with personal care	❒ ❒ ❒ ❒ ❒ ❒ ❒ ❒ ❒ ❒ ❒	❒ ❒ ❒ ❒ ❒ ❒ ❒ ❒ ❒ ❒ ❒
Hearing	Assisting with personal care Client safety Conversations and other sounds	❒	❒
Speaking	Able to understand voice	❒	❒
Vision Colour Depth Spatial	Client safety Medication Meal preparation	❒ ❒ ❒	❒ ❒ ❒
Reading		❒	❒
Walking		❒	❒

Name: _____ Student No: _____

Section 4: To be Completed by Physician (required)

Must be completed by a Physician

Physician/NP Name: _____

Physician/NP Signature: _____

Date: _____

OFFICE STAMP

I have made a copy of this completed form for my records.

Student Name: _____ Student Signature: _____

Dear Health Care Provider:

College students who have placement in a health care setting must complete the attached Medical Report in order to be considered for placement.

Important Things to Note:

A 2-step TB skin test is required. Please ensure all fields are documented on the form, please express interpretation in mm of induration. Even if there is no reaction, there must be 0mm documented. Simply writing 'negative' will not suffice.

Do not vaccinate your patient with MMR, Varicella or COVID 19 vaccines until after TB skin testing is complete.

If patients have had one previous positive TB skin please include documentation of this previous positive test, including mm of induration.

History of BCG vaccine is not a contraindication to TB skin testing.

Please do not receive any Covid-19 vaccine until your TB skin testing is complete. If you have recently received a Covid-19 vaccine, please wait 28 days from the date of administration to start the TB skin testing process. This 28-day waiting period is required as a Covid-19 vaccine can alter the results of the TB skin test.

MMRV vaccination is not approved for use in Canada for patients over the age of 12 per NACI guidelines.
https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci.html

If your patient requires Varicella vaccination the minimum interval between doses is 4 weeks and NACI recommends 6-12 weeks between doses.

All adults working in Health Care settings regardless of age, should receive a single dose of tetanus diphtheria acellular pertussis vaccine (Tdap) for pertussis protection if not previously received in adulthood. The adult dose is in addition to the routine adolescent booster dose.

Please ensure you provide your patient with all patient vaccination records and bloodwork results. Vaccination records and bloodwork results must be translated and provided in English.

Thank you so much for your assistance,

National Association of Career Colleges