HUMBER

UNIVERSITY OF GUELPH HUMBER

HUMBER COLLEGE & UNIVERSITY OF GUELPH-HUMBER
PRE-PLACEMENT RETURNING STUDENT FORM

The information that you provide is **confidential.** It is intended for use by the Humber College Health Centre Staff in order to ensure that the student meets the Immunization Requirements for Clinical Placement.

FRREDOM OF INFORMATION AND PROTECTION OF INDIVIDUAL PRIVACY ACT

The personal information on this form is collected under the legal authority of the Colleges and University Act. R.S.O. 1980 Chapter 272, Section 5, R.R.O. 19990, Regulation 77 and the Public Hospital Act R.S.O. 1980 Chapter 410, R.S.O. 1986 Regulations 65 to 71 and in accordance with the requirements of the legal agreement between the College and the agencies which provide clinical experience to students. The information is used to ensure safety and well-being of students and clients in their care.

PERSONAL INFORMATION

Program of Study: ……Student #……Admission Year: ……

Last Name: …….. First Name (s): ……

Date of Birth: ……
DD/MM/YY

Health Card#…….. Exp. Date: ……..
DD/MM/YY
Province: ……

Address: ……

Tel. #……Email: ……

IMMUNIZATION RECORDS

This is your returning form and a copy of your previous records would be helpful in getting this process started.

TB TESTING

For **RETURNING STUDENTS**, with a documented 2-STEP Tuberculin Skin Test on file, then **ONLY an ANNUAL TB SKIN TEST IS REQUIRED.**

PREVIOUS POSITIVE TB TEST: If you have a documented history of a previous positive TB test (induration measuring equal to or greater than 10 mm) and a copy of a CHEST XRAY on File, then a TB Skin Test is **Not Required. Proceed to have an ANNUAL CHEST ASSESSMENT (and/or updated x-ray as per your health care provider)**

TB Test	Vaccine Name	Date Given	Site/Route/Dose	Date Read (within 48-72 hours)	Results: Indurations in mm	HCP Initials
Annual		dd/mm/yy		dd/mm/yy		

Annual TB Test: If TB test is positive (≥ 10 mm) proceed to Chest X-Ray and Chest Assessment **or** If TB test is negative (<10mm) continue to repeat TB Test annually.

CHEST X-RAY & CHEST ASSESSMENT: Required ONLY if TB reaction is equal to or greater than 10 mm

Date of Chest X-Ray	Results	INH Treatment Prescribed (YES or NO) if No, why?
dd/mm/yy		

ATTACH A COPY OF A RECENT X-RAY REPORT (Mandatory) ☐ **or**

COPY OF a previous XRAY REPORT ON FILE (Mandatory) ☐

ON AN ANNUAL BASIS, STUDENTS WITH A PREVIOUS POSITIVE TB SKIN TEST MUST COMPLETE AN ANNUAL CHEST ASSESSMENT

Date of Chest Assessment	Results **Negative**= no symptoms of active TB **Positive** = symptoms of active TB	HCP initials
dd/mm/yy		

TETANUS, DIPTHERIA and PERTUSSIS VACCINES

Tdap Immunization	Vaccine Name	Date Given	Site/Route/Dose	HCP Initials
Tetanus/Diphtheria/ Pertussis (ADACEL) (at ≥ 14 years)	……	dd/mm/yy		
Tetanus/Diphtheria (Td) (every 10 years)	……	dd/mm/yy		

HEALTH CARE PROVIDER (HCP) INFORMATION

The student has met all the program immunization requirements needed to attend field/clinical placement:

YES ☐ NO ☐

Name & Signature of HCP: _____ Date: _____

Profession: ☐ RPN ☐ RN ☐ NP ☐ MD dd/mm/yy

Address/Clinic Stamp (mandatory):