Clinical Preparedness Permit (Revised June 2018)

Student Name: Last_____First _____

(Please ensure student name appears on each page)

For Collaborative Students only: *College Student Number* _____ *College Student Email* _____

All Students to indicate: York Student Number_____ York Student E-mail _____

Students are required to:

1. **Read the guideline document that accompanies the permit carefully for details related to all of 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 your stamped permit on the first day of the clinical placement.**
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 for placement purposes.**

IMPORTANT: MAKE A PHOTOCOPY OF THIS PERMIT AFTER EACH UPDATE AND STORE IN A SAFE PLACE

Allergy: ☐ No ☐ Yes _____

NOTE: *Any student without any required vaccination will be denied access to the facility, thereby jeopardizing successful completion of the course/practicum.*

Requirement	Page	Page in Guide	Upon Entry	Every Year	Every 2 Years
Vulnerable Sector Police	4	2-3	X	X	
CPR- Level HCP	5	3	X	X	
Standard First Aid ***Students in Collaborative Program only.***	5	3	X		
Worker Health and Safety Awareness Certificate and WHMIS Certificate	5	4	X		X
Respirator Mask Fit Test	5	4	X		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 Name: Last_____First _____

Medical Requirements (To be completed by Health Care Provider)

Mandatory Lab Reports (To be completed by Health Care Provider			
Mantoux Skin Test	**Date Given**	**Date Read** (48-72h from test)	**Induration (mm)**
Baseline 2-Step Step 1			
Step 2 (7-28 days after Step 1)			
Step 1 (Required Annually)			
Step 1 (Required Annually)			
Step 1 (Required Annually			
Step 1 (Required Annually			
Step 1 (Required Annually			
Chest x-ray – Date & Result			
Chest x-ray – Date & Result			
(Health Care Providers letter attached, if applicable)			
Health Care Provider Signature			

MMR (Measles, Mumps, Rubella) and Varicella			
All students are required to complete the below section, and keep a hard copy of lab results with this package at all times. Lab Reports (titres) Results:			
	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 Name: Last_____First _____

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 of Primary Series	
Date of Booster	
OR Adacel (1 dose) Date Given	
Health Care Provider Signature	

Hepatitis B

All students are required to complete the below section, and keep hard copy of lab results with this package at all times.

Lab Reports (titres) Results:

Immunity	☐ Yes ☐ No ☐ Indeterminate
1st Vaccination Date	
2nd Vaccination Date (within 1 month of 1st)	
3rd Vaccination Date (6 months after 1st)	
Health Care Provider Signature	

Hepatitis B
Negative or Indeterminate Immunity Result

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 Name: Last_____First _____

Influenza Vaccination (Flu Shot)			
ANNUAL IMMUNIZATION VACCINE ONLY AVAILABLE DURING FLU SEASON (OCTOBER/NOVEMBER) *Any student without the vaccination may be denied access to the facility, thereby jeopardizing successful completion of the course/practicum.* ☐ *Student is medically unable to receive flu shot* *Health Care Provider Signature: _____*	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* dependent on clinical agency). *All students are required to complete the below section, and keep hard copy of certificate with this package at all times.*	
Police Check Service (Police Region)	Date of Issue

Student Name: Last_____First _____

CPR at the Health Care Provider Level (CPR-HCP) *All students are required to complete the below sections, and keep hard copy of certificate with this package at all times*	
Company	Date of Issue
Standard First Aid *Collaborative students only upon program entry*	
Company	Date of Issue

Ministry of Labour's Worker Health and Safety Awareness Certification (Completed Every Two Years) *All students are required to complete the below section, and keep hard copy of certificate with this package at all times.*	
Date of Issue (College) *Collaborative students only*	
Date of Issue (York)	
WHMIS (Completed Every Two Years)	
Date of Issue (College) *Collaborative 1st & 2nd Year students only*	
Date of Issue (York) *All program students*	

Respirator Mask Fit Testing (Completed Every Two Years) *All students are required to complete the below section, and keep hard copy of certificate with this package at all times.*			
Date of issue upon entry to program		Date of issue after 2 years	

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Clinical Preparedness Permit (Revised June 2018)

Seneca Georgian

Student Name: Last_____First _____

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 requirements.

Proceed to: _____
Approved by: _____
Date: _____
~~Verification of Clearance~~

Proceed to: _____
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Date: _____
Verification of Clearance

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Verification of Clearance

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Approved by: _____
Date: _____
Verification of Clearance

Student Name: Last_____First _____

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:	