

**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:	Requirement	Page	Page in Guide	Upon Entry	Every Year	Every 2 Years
<ol style="list-style-type: none"> <li>1. Read the guideline document that accompanies the permit carefully for details related to all of components of the clinical preparedness permit.</li> </ol>	Vulnerable Sector Police	5	2-3	X	X	
<ol style="list-style-type: none"> <li>2. <i>Have an authorized health care provider sign-off and provide the appropriate lab report(s) to support the immunization record.</i></li> </ol>	CPR- Level BLS (course for healthcare providers NOT for the general public)	6	3	X	X	
<ol style="list-style-type: none"> <li>3. Present this permit and original documents for verification stamping each term. <i>The student will not enter clinical placement unless the permit is stamped.</i></li> </ol>	Standard First Aid <i>Students in Collaborative Program only.</i>	6	3	X		
<ol style="list-style-type: none"> <li>4. Bring your stamped permit on the first day of the clinical placement.</li> </ol>	Worker Health and Safety Awareness Certificate and WHMIS Certificate	6	4	X		X
<ol style="list-style-type: none"> <li>5. Make sure the permit or copy is available to present if requested at the clinical placement site.</li> </ol>	Respirator Mask Fit Test	6	4	X		X
<ol style="list-style-type: none"> <li>6. It is the responsibility of the student to keep this form and associated documents current for placement purposes.</li> </ol>	Base-line Two-Step OR One-Step Mantoux Skin Test	2	5	X		
<p><b>IMPORTANT: MAKE A PHOTOCOPY OF THIS PERMIT AFTER EACH UPDATE AND STORE IN A SAFE PLACE</b></p>	One-Step Mantoux Skin Test	2	5		X	
<p>Allergy: <input type="checkbox"/> No <input type="checkbox"/> Yes _____</p>	Immunizations & Titres	2-3	5, 6, 7	X		
<p><b>NOTE:</b> Any student without any required vaccination will be denied access to the facility, thereby jeopardizing successful completion of the course/practicum.</p>	Flu Vaccination (in October/November)	4	7		X	
	COVID-19 Vaccination	4				



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**Medical Requirements (To be completed by Health Care Provider)**

<b>Mandatory Lab Reports (To be completed by Health Care Provider)</b>				<b>MMR (Measles, Mumps, Rubella) and Varicella</b>	
<b>Mantoux Skin Test</b>	<b>Date Given</b>	<b>Date Read (48-72h from test)</b>	<b>Induration (mm)</b>	<i>All students are required to complete the below section, and keep a hard copy of lab results with this package at all times.</i>	
				Lab Reports (titres) Results:	
<b>Baseline 2-Step Step 1</b>					<b>Immunity</b>
<b>Step 2 (7-28 days after Step 1)</b>				Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate
Step 1 (Required Annually)				Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate
Step 1 (Required Annually)				Rubella	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate
Step 1 (Required Annually)				Varicella	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate
Step 1 (Required Annually)				<i>If lab results show .no" or "indeterminate" immunity for any of the above, a booster is required and no further titres are required.</i>	
Step 1 (Required Annually)				<b>BOOSTER:</b>	<b>DATE GIVEN:</b>
				MMR	
				Varicella	
Chest x-ray – Date & Result					
Chest x-ray – Date & Result					
<i>(Health Care Providers letter attached, if applicable)</i>					
 Health Care Provider Signature				 Health Care Provider Signature	

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<b><u>Polio</u></b>		<b><u>Tetanus/Diphtheria (TD)/ Pertussis</u></b>	
Date Primary Series Completed		Date of Last Tetanus	
<b>OR</b> Date of Last Booster (if required)		Date of Primary Series	
 Health Care Provider Signature		Date of Booster	
		<b>OR</b> Adacel (1 dose) Date Given	
		 Health Care Provider Signature	

<b><u>Hepatitis B</u></b> <i>All students are required to complete the below section, and keep hard copy of lab results with this package at all times.</i>		<b><u>Hepatitis B</u></b> <b><u>Negative or Indeterminate Immunity Result</u></b> <i>For non-responders, additional doses, up to another complete series of three, can be done, with testing for response after each dose.</i>	
Lab Reports (titres) Results:		If applicable - Start date of second series	
Immunity	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate		
1 <sup>st</sup> Vaccination Date		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.	
2 <sup>nd</sup> Vaccination Date (within 1 month of 1 <sup>st</sup> )			
3 <sup>rd</sup> Vaccination Date (6 months after 1st)			
 Health Care Provider Signature		 Health Care Provider Signature	

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COVID-19 Vaccination	Year of Program	Single-dose vaccine date	1 <sup>st</sup> dose of 2-step vaccine date	2 <sup>nd</sup> dose of 2-step vaccine date	Health Care Provider Signature
<p><i>This vaccination may be required by select practicum sites for access to their facility and patient population. Any student without the vaccination may be denied access to the facility, thereby jeopardizing successful completion of the course/practicum.</i></p> <p><input type="checkbox"/> Student is medically unable to receive COVID-19 vaccination</p> <p>Health Care Provider Signature: _____</p>	1 <sup>st</sup> Year				
	2 <sup>nd</sup> Year				
	3 <sup>rd</sup> Year				
	4 <sup>th</sup> Year				

<b>Influenza Vaccination (Flu Shot)</b>			
ANNUAL IMMUNIZATION VACCINE ONLY AVAILABLE DURING FLU SEASON (OCTOBER/NOVEMBER)	Year of Program	Date Received	Health Care Provider Signature
<p><i>Any student without the vaccination may be denied access to the facility, thereby jeopardizing successful completion of the course/practicum.</i></p> <p><input type="checkbox"/> Student is medically unable to receive flu shot</p> <p>Health Care Provider Signature: _____</p>	1 <sup>st</sup> Year		
	2 <sup>nd</sup> Year		
	3 <sup>rd</sup> Year		
	4 <sup>th</sup> Year		

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**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





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<p><b><u>CPR at the Health Care Provider Level (BLS)</u></b>  <i>All students are required to complete the below sections, and keep hard copy of certificate with this package at all times</i></p>		<p><b><u>Ministry of Labour's Worker Health and Safety Awareness Certification (Completed Every Two Years)</u></b>  <i>All students are required to complete the below section, and keep hard copy of certificate with this package at all times.</i></p>	
Company	Date of Issue	Date of Issue (College) <i>Collaborative students only</i>	
		Date of Issue (York)	
		<b><u>WHMIS (Completed Every Two Years)</u></b>	
		Date of Issue (College) <i>Collaborative 1<sup>st</sup> &amp; 2<sup>nd</sup> Year students only</i>	
<b><u>Standard First Aid</u></b> <i>Collaborative students only upon program entry at the college</i>		Date of Issue (York) <i>All program students</i>	
Company	Date of Issue		
<b><u>Respirator Mask Fit Testing (Completed Every Two Years)</u></b> <i>All students are required to complete the below section, and keep hard copy of certificate with this package at all times.</i>			
Date of issue upon entry to program		Date of issue after 2 years	

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

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

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

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

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Official HCP Stamp:	
Telephone:	
Signature:	
Date:	