Clinical Preparedness Permit (Updated Feb 2021)

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	5	2-3	X	X	
CPR- Level BLS **(course for healthcare providers NOT for the general public)**	6	3	X	X	
Standard First Aid ***Students in Collaborative Program only.***	6	3	X		
Worker Health and Safety Awareness Certificate and WHMIS Certificate	6	4	X		X
Respirator Mask Fit Test	6	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	
COVID-19 Vaccination	4				

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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	

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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	

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COVID-19 Vaccination	Year of Program	Single-dose vaccine date	1st dose of 2-step vaccine date	2nd dose of 2-step vaccine date	Health Care Provider Signature
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.	1st Year				
	2nd Year				
	3rd Year				
	4th Year				
☐ *Student is medically unable to receive COVID-19 vaccination* *Health Care Provider Signature:* _______________					

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

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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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CPR at the Health Care Provider Level (BLS)

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

Mi. istry 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*	

Standard First Aid

Collaborative students only upon program entry at the college

Company	Date of Issue

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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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

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Verification of Clearance

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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:	