

In order to comply with health requirements as set out in the Public Hospitals Act, other applicable law, or LHSC policies, prior to coming on-site to LHSC:

- The learner must obtain immunizations/blood work, TB tests and documentation as required (any costs incurred are the responsibility of the learner);
- The school/educational institution must ensure that the requirements are fulfilled before the Learner's anticipated start date.

Learners who are diagnosed with a medical condition (before or during placement) that could pose a risk to themselves or others (i.e. injury that requires the use of an assistive device, an allergy, immune-compromised status, psychological or emotional based illnesses, etc.) should contact the School for their fitness to be on placement to be assessed and to address any accommodation issues.

Anticipated Start Date of Clinical Placement (YYYY/MM/DD):			
Anticipated End Date of Clinical Placement (YYYY/MM/DD):			
First Name:		Last Name:	
Gender:	Date of Birth (YYYY/MM/DD):	Family Physician:	
Home Phone:	Cell Phone:	Email:	
Emergency Contact Person:		Contact's Phone:	
Hospital Location of Placement: <input type="checkbox"/> University Hospital <input type="checkbox"/> Victoria Hospital/Children's Hospital			
LHSC Placement Supervisor:			Extension:

Do you have any <u>food or drug/vaccine allergies</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details: _____

Please complete the following immunization / history section (MUST provide proof)

Proof of immunization is required and includes any of the following:

- Vaccination records from yellow immunization cards
- Immigration records
- Notes from physician's offices
- Copies of laboratory reports (titres)
- Health Unit records
- Other hospital electronic immunization records (provided they are signed by a physician or nurse)

Immunization	Requirements
Red Measles	Require proof of 2 Red Measles-containing vaccines <u>OR</u> lab results indicating immunity
Mumps	Require proof of 2 Mumps-containing vaccines <u>OR</u> lab results indicating immunity
Rubella	Require proof of 1 Rubella-containing vaccine <u>OR</u> lab results indicating immunity

Vaccine/Titre Type	Date yyyy/mm/dd	Result
MMR Vaccine (Measles / Mumps / Rubella)	1.	
	2.	
Red Measles only Vaccine		
Red Measles Titre		
Mumps Titre		
Rubella Titre		

Immunization	Requirements	Vaccine Type	Date of Vaccine	Titre	
				Date	Result
Varicella (Chicken pox)	History (Hx) of Chicken Pox? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Require vaccine <u>OR</u> titre if no Hx	Varicella	1.		
			2.		
Hepatitis B Vaccination	Strongly recommend vaccine if risk of exposure to blood/body fluids	Hepatitis B	1.		
			2.		
			3.		
Tetanus- Containing Vaccinations:	Recommend vaccine every 10 years. Require an adult one-time dose of Adacel	Tetanus/Diphtheria (Td)	Most recent:		
		Tetanus/Diphtheria/Polio (TdP)	Most recent:		
		Tetanus/Diphtheria/Pertussis (Adacel)	Most recent:		
Meningitis	Vaccine may be recommended if working in Microbiology Laboratory	Type:			
Seasonal Flu	Required October 1 – March 31	Type:	Most recent:		
COVID 19 #1	Required	Brand Name	Date		
COVID 19 #2	Required	Brand Name	Date		

TB Skin Test:

- The 2 step TB skin test is given 1-52 weeks apart from the first single TST.
- If 2-step TB skin test was completed more than 12 months ago, a 1-step TB test must be completed.
- If 1st or 2nd test is POSITIVE (i.e. greater than 10mm induration): Chest x-ray is required to be completed, post-positive test.

2 Step TB Skin Test (required if not previously done)	Annual TB Skin Test	If TB Skin Test <u>positive</u> in the past:	
1st Step TB Skin Test Date: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	(required within the past 12 months unless 2 Step was done within that time) Date: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Date of Test:	
		Redness (mm):	Induration (mm):
2nd Step TB Skin Test (within 12 months of 1st step) Date: <input type="checkbox"/> Negative <input type="checkbox"/> Positive		Positive results have been previously investigated? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes attach consult note)	
		Date of X-ray (Must be within past year; attach proof):	
		Treatment for TB infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Date of Treatment:	

Have you been fit-tested within the last 2 years to wear an N95 respirator? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate which model and size.

Signature _____ Date: _____