Georgian **Student Name:** _____ **Student Number:** _____

GEORGIAN COLLEGE HEALTH, WELLNESS AND SCIENCES
CLINICAL PREPAREDNESS PERMIT

Notice: *Upon your* ***acceptance*** *into this program, it is your* ***responsibility*** *to start and meet all of the requirements outlined below. This process will take* ***10 – 12 weeks*** *to complete and it is your sole responsibility to ensure you maintain and update these requirements as needed for the duration of your program.*

This is the Georgian College Health, Wellness and Sciences Clinical Preparedness Permit. Georgian College works in collaboration with Synergy Gateway, a third party, for recordkeeping and tracking program requirements. ***Georgian College reserves the right to issue a pass or a fail for a clinical permit.***

If you ***fail*** *to MEET these requirements by the given deadline, you* ***will be excluded*** *from clinical practice as per Ontario legislation that specifies certain surveillance requirements for those entering into a practice setting that are in accordance with the Public Hospitals Act and are based on the Canadian Immunization Guide, Evergreen Edition and Canadian TB Standards, which can jeopardize your academic standing and lead to program* ***withdrawal without refund****. All costs, service fees and fines associated with the overall requirements and potentially the program withdrawal are the responsibility of the student.*

_____ Student Initials

MEDICAL REQUIREMENTS *(Mandatory)*

Book an appointment with your Physician/Walk-In Clinic/Health Care Practitioner. Bring this Permit form and the Information Package to your appointment and advise your physician to complete, sign and stamp your health form documents.

Please read and follow all details and instructions in the Information Package and on pages 2-3 of this document*.*

- ✓ COVID-19 vaccination – "fully vaccinated" is defined as 14 days after 2nd dose (*ask your doctor to document all dates)*
- ✓ Tetanus, Diphtheria & Pertussis *(Tdap-valid every 10 years, ask your doctor to document all dates)*
- ✓ Measles, Mumps & Rubella (*if serology needed, ATTACH copy of laboratory test report)*
- ✓ Varicella (*if serology needed, ATTACH copy of laboratory test report)*
- ✓ Polio (*ask your doctor to document all dates)*
- ✓ Seasonal Flu Shot (*every year in November/December)*
- ✓ Hepatitis B *(ask your doctor to do serology, ATTACH copy of laboratory test report)*
- ✓ Tuberculosis Skin Test *(ask your doctor to document all TB dates given, dates read & induration results)*
- ✓ Final Signature of Doctor/Physician & medical office stamp
- ✓ Yellow immunization card or any type of immunization records

ADDITIONAL REQUIREMENTS (Mandatory)

Please apply for your police record vulnerable sector check and certificate below and upload all originals for your scheduled Electronic Requirements Verification appointment on Synergy Gateway's Verified system.

Please read and follow all details and instructions in the Information Package and on pages 2-4 of this document.

- ✓ Police Vulnerable Sector Check
- ✓ Standard First Aid
- ✓ CPR (Level HCP or BLS) Certificate Card
- ✓ Mask Fit Test Certificate Card
- ✓ WHMIS Certificate
- ✓ Ministry of Labour Worker Safety and Awareness Certificate
- ✓ WSIB Declaration
- ✓ Combined Confidentiality, Conflict of Interest and Clinical Permit form
- ✓ Any other requirements specific to your status or program *(see #17, 18 & 19)*
- ✓ Fill-out & complete all of the top sections with your Name and Student number
- ✓ Verified by Synergy Gateway – Electronic Requirements Verification (ERV) Appointment & Service Fees

Georgian **Student Name:** _____ **Student Number:** _____

PHYSICIAN/HEALTH CARE PROFESSIONAL TO COMPLETE, SIGN & STAMP

Other than the influenza vaccine (page 2, #5), the completion of this information is not optional, and all sections must be completed as outlined. If, for medical reasons, your patient is unable to receive a required immunization or Chest X-ray, a medical note of this exclusion must be provided on this form.
***Note**: If you **do not** have your old immunization record, you must contact your doctor's office or your regional Public Health and ask them to send you a copy. Please refer to the Information Package for specific requirements.*

MEDICAL REQUIREMENTS (Mandatory)

1. **COVID-19** ***(Health Care Professional - document all doses as outlined below) - Refer to Information Package Page 5, Section 1 for requirements.***

☐ Date of Primary Series

1st dose date ____/_____/_____ (month/day/year) *Vaccine Manufacturer 1st dose* _____

2nd dose date ____/_____/_____ *Vaccine Manufacturer 2nd dose* _____

NOTE: In lieu of a COVID-19 vaccine, some clinical agencies ***may*** accept a medical note exemption from your physician. Ask your doctor for this if you are unable to be immunized for medical reasons and be prepared to share it with the clinical agency.

2. **TETANUS, DIPHTHERIA & PERTUSSIS** ***(Health Care Professional - check the appropriate box and document all doses as outlined below) - Refer to Information Package Page 5, Section 2 for requirements.***

☐ Received routine childhood immunizations (please circle): *Yes No*

☐ Date of Primary Series

1st dose date ____/_____/_____ (month/day/year)

2nd dose date ____/_____/_____

3rd dose date ____/_____/_____

☐ Date of one-time Adult pertussis-containing Booster ____/_____/_____ *(month/day/year)*

☐ Date of last Td Booster ____/_____/_____ ***(Td vaccine must be UPDATED at least every 10 years)***

3. **MEASLES, MUMPS & RUBELLA (MMR)** ***(Health Care Professional - check the appropriate box depending on patient's medical history and document all doses as outlined below). Refer to Information Package Page 5, Section 3, to see whether you need to have serology completed by the lab.***

☐ Evidence of vaccination with two doses of MMR (at least one month apart after one year of age)

1st dose date ____/_____/_____ (month/day/year)

2nd dose date ____/_____/_____

☐ Immunity/Reactive blood test result (**Note:** NO injections required; it is mandatory that you ATTACH a copy of most recent MMR laboratory blood test report.)

☐ Non-Reactive/Non-Immunity/Indeterminate lab test result (**Note:** is it mandatory that you ATTACH a copy of most recent laboratory blood test report and get a booster dose)

Booster dose date ____/_____/_____ (month/day/year)

Booster dose date ____/_____/_____ (month/day/year)

4. **VARICELLA (CHICKEN POX)** ***(Health Care Professional - check the appropriate box depending on patient's medical history and document all doses as outlined below). Refer to Information Package Page 5, Section 4 to see whether you need to have serology completed by the lab.***

☐ Evidence of vaccination with two doses

1st dose date ____/_____/_____ (month/day/year)

2nd dose date ____/_____/_____

☐ Immunity/Reactive lab test result (**Note:** NO injections required; it is mandatory that you ATTACH a copy of most recent laboratory blood test reports valid within 5 years)

☐ Non-Reactive/Non-Immunity/ Indeterminate lab test result (**Note:** it is mandatory that you ATTACH a copy of most recent laboratory blood test report and get a booster dose)

Booster dose date ____/_____/_____ (month/day/year)

5. **POLIO** ***(Health Care Professional - check the appropriate box and document all doses as outlined below) – Refer to Information Package Page 5, Section 5 for requirements.***

☐ Received routine childhood immunizations including Polio (please circle): *Yes No*

☐ Date of Primary Series

1st dose date ____/_____/_____ (month/day/year)

2nd dose date ____/_____/_____

3rd dose date ____/_____/_____

6. **SEASONAL FLU SHOT** ***(every year in October/November) – Refer to Information Package Page 5, Section 6 for requirements.***

☐ *Seasonal Flu Shot Given Date_____/_____/_____ (month/day/year)*

Final Signature of Physician/Healthcare Professional: _____

Date (month/day/year): _____ **Medical Office Stamp:** _____

MEDICAL REQUIREMENTS Cont. (Mandatory)

7. **HEPATITIS B** ***(Health Care Professional - check the appropriate box, ATTACH a copy of lab blood test reports and document all doses as outlined below.)*** ***Refer to Information Package Page 6, Section 7 for requirements*****. Serology is MANDATORY to inform response in cases of acute infection.**

- ☐ Date of Primary Series – **mandatory information**
  Patient received a 2-dose series of Hep B vaccine in Grade 7 in Ontario (please circle): *Yes* *No*
  1st dose date ____/_____/_____ (month/day/year)
  2nd dose date ____/_____/_____
  3rd dose date ____/_____/_____
- ☐ Immunity/Reactive/Positive lab test result (**Note:** NO injections required; it is mandatory that you ATTACH a copy of most recent "Antibody" laboratory blood test report)
- ☐ Non-Immunity/Non-Reactive/Negative/Low lab test result (**Note:** it is mandatory that you ATTACH a copy of the "Antibody" laboratory blood test report and get the following doses)
  1st booster dose date ____/_____/_____ (month/day/year)
  At least one month after the 1st booster dose, get a 2nd dose
  2nd booster dose date ____/_____/_____ (repeat blood test after 4 to 6 weeks, if result is Non-reactive/Negative, get a 3rd dose)
  3rd booster dose date ____/_____/_____ (due six months after 1st dose, repeat blood test after 4 to 6 weeks)
- ☐ 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.
- ☐ Carrier *(**Note:** No injections required and ATTACH copy of most recent "Antigen Positive" blood test and notify the medical officer of health. These results will be evaluated in collaboration with experts in the field and relevant professional college. **THIS MAY RESULT IN A FAILED PERMIT**.)*

8. **TWO CONSECUTIVE STEP-TUBERCULOSIS (MANTOUX) SKIN TEST (*Health Care Professional* please complete)–*Refer to Information Package Page 6, Section 8 to determine if you require a 1 Step, 2 Step or Chest X-ray. DO NOT proceed with any testing until you have carefully reviewed the Information Package.***

ONE STEP MANTOUX SKIN TEST
_____ / _____ / _____
Date Given (month/day/year) *Date Read - 48-72 hours after date given* *Induration size (mm)*

TWO STEP MANTOUX SKIN TEST *(7-28 days after One Step)*
_____ / _____ / _____
Date Given on opposite arm (month/day/year) *Date Read - 48-72 hours after date given* *Induration size (mm)*

ONE STEP MANTOUX SKIN TEST – Required Annually
_____ _____/_____/_____
Date Given (month/day/year) *Date Read - 48-72 hours after date given* *Induration size (mm)*

ONE STEP MANTOUX SKIN TEST – Required Annually
_____ _____/_____/_____
Date Given (month/day/year) *Date Read - 48-72 hours after date given* *Induration size (mm)*

ONE STEP MANTOUX SKIN TEST – Required Annually
_____ _____/_____/_____
Date Given (month/day/year) *Date Read - 48-72 hours after date given* *Induration size (mm)*

OR Chest X-ray
_____ _____/_____
Date of X-ray (month/day/year) *Result of Chest X-ray*

_____ _____/_____
Date of X-ray (month/day/year) *Result of Chest X-ray*

Final Signature of Physician/Healthcare Professional: _____

Date (month/day/year): _____ **Medical Office Stamp:** _____

Student to read and sign if unable to meet the Immunization Requirements:

Given my inability to demonstrate immunity to these or other communicable diseases, I understand that I may be at a greater risk of contracting potentially life-threatening illnesses while participating in my placement. I also understand that my placement setting may decline my request for placement as a result of these missing immunizations and that this may lead to consequences up to, and including, the inability to complete the placement requirements for my program.

X _____ _____
(Signature) **(Date)**

Georgian **Student Name:** _____ **Student Number:** _____

ADDITIONAL REQUIREMENTS (Mandatory) – Refer to Information Package pages 6-8 for requirements.

9. **POLICE VULNERABLE SECTOR CHECK** - ***Issued Date***_____/_____/_____ *(month/day/year)*
10. **STANDARD FIRST AID** - ***Issued Date*** _____/_____/_____ *(month/day/year)* ***Expiry Date***_____/_____/_____
11. **CPR (LEVEL HCP or BLS) CERTIFICATE – Recertified Annually** - ***Issued Date*** _____/_____/_____ ***(Expires one year after the date issued)***
12. **MASK FIT TEST –** ***renew every two years*** - ***Issued Date*** _____/_____/_____ ***(Expires two years after the issued date)***
13. **WHMIS CERTIFICATE**
14. **MINISTRY OF LABOUR WORKER HEALTH AND SAFETY AWARENESS CERTIFICATE**
15. **WSIB STUDENT DECLARATION**
16. **COMBINED CONFIDENTIALITY, CONFLICT OF INTEREST, CLINICAL PERMIT FORM**
17. **For Massage Therapy Students ONLY – Public Health Ontario – Infection Prevention and Control, Core Competency Modules and Certificates**
18. **For second year Primary Care Paramedic (PCP) Students ONLY – Health Status Report-Communicable Diseases**
19. **For INTERNATIONAL Students ONLY – International Student Co-op Work Permit (in addition to Study Permit)**

GEORGIAN COLLEGE AGREEMENT FORM

(Complete prior to your permit checking appointment)

Student Name: _____

Program: _____

I, _____ *(Print Name), understand that any false statement is grounds for cancellation of admission.*

I understand that the college has the right to cancel my admission privilege based on medical information submitted or withheld. I understand that it is my responsibility to inform my Program Coordinator of any communicable disease, special need, exception or medical condition, which may place me at risk or pose a risk to others at Georgian College or on placement.

I will pay all the services fees and authorize Synergy Gateway to review the above information.

I have read and understand what a "Failed Permit" means as stated on Page 4 of the Information Package.

I attest that I have never had a 'no trespass order' placed against me at Grey Bruce Health Services or any other healthcare setting in which I may be placed.

x_____ _____

(Signature) **(Date)**

ELEMENT OF RISK

All experiential learning programs, such as field trips, clinical and field placements or job shadowing involve certain elements of risk. These may occur while participating in experiential learning activities without any fault of the student, the placement or the college. By taking part in these activities, I am accepting that there are certain risks and dangers including but not limited to illness, infection, bodily injury, or exposure to communicable diseases. By signing below I hereby release Georgian College, its employees, board of governors, faculty, agents, contractors and assign ("Releasees") and waive any and all claims that I have or may in the future have against the Releasees and to release the Releasees from any and all liability for any loss, damage, expense or injury including death that I may suffer, or that my next of kin may suffer as a result of my participation in activities, due to any cause whatsoever, including but not limited to, negligence, or breach of any statutory or other duty of care, including the failure on the part of the Releasees to take reasonable steps to safeguard or protect me from the risks, dangers and hazards of the activities referred to above. This Release Agreement shall be effective and binding upon my heirs, next of kin, executors, administrators, assigns and representatives, in the event of my death or incapacity.

x_____ _____

(Signature) **(Date)**

FREEDOM OF INFORMATION AND PROTECTION OF INDIVIDUAL PRIVACY ACT The personal information on this form is collected under the legal authority of the Colleges and Universities Act, R.S.O. 1980, Chapter 272, Section 5, R.R.O. 1990, Regulation77 and the Public Hospital Act R.S.O.1980 Chapter 410, R.S.O. 1986, Regulations65 to 71 and in accordance with the requirements of the legal Agreement between the College and the agencies which provide clinical experience for students. The information is used to ensure the safety and wellbeing of students and clients in their care.