Saint Elizabeth
HEALTH CAREER COLLEGE

IMMUNIZATION AND PHYSICAL FITNESS FORM INSTRUCTIONS

As part of the admission requirements for the HCA Diploma Program and the CHR Certificate Program students are required to provide medical evidence completed by a licensed physician or nurse practitioner which states the applicant is in good physical and mental health. Proof of up-to-date immunization for preventable diseases and negative TB test are also a requirement.

No student will be able to commence practice education placements or practicums until the following medical documents have been obtained and submitted to the College. For immunizations, please see your local Health Centre/Office, Nursing Station or your family doctor.

The following list is the required vaccinations for preventable diseases:

- Diphtheria/Tetanus
  - Proof of basic immunization and booster in past 10 years
- Poliomyelitis
  - Proof of basic immunization series of polio vaccine plus single booster dose after 10 years of primary series
  - Those with no basic series should have the series completed regardless of interval of last dose
- Measles, Mumps and Rubella (MMR)
  - For those born after 1957, proof of two doses of MMR vaccine or reactive serology test for immunity
- Varicella (chicken pox)
  - Proof of vaccination or a positive history
- Hepatitis B
  - Proof of Hepatitis B vaccine series
- Influenza Vaccination
  - Proof of annual vaccine
- Tuberculosis (TB)
  - A negative skin test dated within 6 months of the first placement
  - For those with a positive skin test a negative chest x-ray is required within a year of the first practice placement

Please submit the completed form by mail, e-mail or confidential fax to:

Program Administrator
Saint Elizabeth Health Career College
Long Plain First Nation
472 Madison St.
Winnipeg, MB
R3J 1J1
e-mail: atyoursidefni@saintelizabeth.com or Confidential Fax: 1-844-883-2091

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HEALTH CARE AIDE (HCA) DIPLOMA PROGRAM/COMMUNITY HEALTH REPRESENTATIVE (CHR) CERTIFICATE PROGRAM
PRE-ADMISSION MEDICAL HEALTH RECORD

Program Name:	Program Start Date:
Last Name:	First Name:
Telephone Number:	e-mail address:
Address (Community Name, Province, Postal Code)	

IMMUNIZATION

TO COMPLETE THIS FORM

1. Check with your family doctor or local health unit (Nursing Station, Health Centre) for your childhood immunization records.
2. Take your immunization records and this form to your doctor or nurse practitioner to review and complete.

*Dates to be in DD/MM/YYYY format

TETANUS/DIPHTHERIA Tetanus, Diphtheria☐ Tetanus, Diphtheria and Polio ☐	Yes ☐ No ☐ No Record ☐ Date of last Tetanus Vaccination:
POLIO Childhood primary series	Yes ☐ No ☐ No Record ☐ Date of last Polio Vaccination:
MEASLES, MUMPS AND RUBELLA Mandatory: 2 documented MMRs	Yes ☐ No ☐ No Record ☐ MMR #1 Date: MMR #2 Date:

VARCELLA (CHICKEN POX) History of disease or herpes zoster? Yes ☐ No ☐ If Yes, Date: *If yes, no titre is required. *If no, titre is required and Adult Primary Series of 2 doses required if there is inadequate immunity	Immunization: Yes ☐ No ☐ No Record ☐ Date of Varicella Vaccinations: Dose #1 Date: Dose #2 Date:
Hepatitis B (Recommended) Primary Series (3 doses) completed	Yes ☐ No ☐ No Record ☐ Dates of Hepatitis B Vaccinations: Dose #1 Date: Dose #2 Date: Dose #3 Date:
Influenza (Recommended)	Yes ☐ No ☐ Date of last Flu Vaccine:
TESTS REQUIRED (Before starting the Health Care Aide Certificate Program)	
Tuberculosis Tests (Required) TB Skin Test (Two Step Mantoux) required. Note: If the TB Skin Test is positive, it must be followed up with an x-ray. If the x-ray is positive for TB the individual will not be admitted into the HCA Certificate Program.	1st Test Result _____ Date: _____ 1st Test Result _____ Date: _____
Chest X-RAY (if Mantoux positive)	Result _____ Date: _____
Rubella Titre (if not immunized)	Result _____ Date: _____
Varicella Titre (if not immunized)	Result _____ Date: _____
Hepatitis B surface Antigen (post-immunization or not immunized)	Result _____ Date: _____
Hepatitis B surface Antibody (if antigen is positive)	Result _____ Date: _____

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CHECK LIST OF ESSENTIAL PHYSICAL ABILITIES			
Physical Demand	**Sample Duties**	**Demonstrated Ability**	
		Yes	No
Lifting (up to 25 kg)	Laundry, groceries, use of equipment (lifts, vacuum, etc.)		
Carrying and shifting weight (up to 25 kg)	Client transfers and positioning, assisting with personal care, groceries, laundry		
Mobility: • Limbs/back • Bending • Crouching • Kneeling • Balancing • Sitting • Standing (possibly for long periods) • Climbing stairs (leg and knee flexibility) • Pushing and pulling • Reaching • Hand/arm and shoulder dexterity	• Housekeeping duties • Client transfers and repositioning • Assisting with personal care		
Hearing	• Assisting with personal care • Client safety • Conversations and other sounds		
Vision: • Colour • Depth • Spatial	• Client safety • Medication • Meal preparation		

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PHYSICIAN OR NURSE PRACTITIONER COMPLETING THE REPORT

Is the applicant fit physically? Yes ☐ No ☐

I certify that the information contained within this report is accurate and up-to-date.

_____ _____

(Name: Please Print) (Telephone)

_____

(Address)

X_____ _____

(Signature) (Date)