



# Directions for PARAMEDICS Medical Requirement Forms (2022-2023 Academic Year)

Ontario regulations and St. Clair College's Policy require health-screening for those entering a clinical/field placement setting in the Paramedic Program.

**You must closely follow these directions. Make an appointment with your Physician as soon as you receive these forms or call the Health Centre. **NOTE: This process may take up to 2 months. Failure to complete it on time may result in your inability to attend and complete your clinical experience.****

This package contains 3 pages: (1) Instructions, (2) Vaccine Preventable Disease Immunization Form, and (3) Physical Examination. You must fill out the top portions of page 2 and 3.

Please obtain your immunization record from your Family Physician or online through your local Public Health Unit.

Along with your immunization record, you must also provide: copies of lab serology showing immunity and any prior TB skin test or chest x-ray reports.

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If no prior TB skin test, a 2 step TB skin test is **mandatory** (administered minimum 1 week apart) If there is proof of a previous 2 step TB skin test, only a 1 step TB test is required.

If there is a record of a previous negative 1 step TB skin test in the past 12 months, only a 1 step TB test is required to be considered a 2 step.

A TB skin test is **NOT** required for anyone who has had a previous positive TB skin test (>10mm). In this case, you should not receive another TB skin test and may require a chest x-ray instead.

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Once all forms have been completed, it is your responsibility to upload them into SIS (Student Information System) where you will be issued your "**Passport to Health**". This must be printed out prior to attending clinical.

You must also complete the Medical Consent Form and Health History Questionnaire in SIS in order for approval.

Please upload all files as **.docx**, **.pdf**, or **.jpeg** in order to review and approve accordingly. Students will be advised via e-mail through SIS of missing documents or of any changes to be made.

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If you have any questions or concerns about the requirements, please contact the Campus Health Centres:

Windsor Main (519) 972-2727 ext. 4484

Windsor Downtown (519) 252-8311 ext. 5117

Chatham (519) 354-9100 ext. 3729

**All information contained in the Medical Requirements Forms will be held with strictest confidence in the St. Clair College Health Centre. It is not shared with anyone outside of the St. Clair College Health Centre without the student's written consent. In the event that the student has a medical emergency or requires medical/nursing attention at the college, the information will assist the Health Centre staff to provide safe and appropriate care to the student.**



Program: PARAMEDIC PROGRAM

Student I.D. # \_\_\_\_\_

Name: \_\_\_\_\_  
 (Surname) (First name) (Middle initial)

**NOTE TO STUDENT:** If you have documentation of the following immunizations, please bring proof of the documentation with this form to your physician.

**VACCINE PREVENTABLE DISEASE IMMUNIZATION FORM**

VACCINE	REQUIREMENT	DATES OF IMMUNIZATION	SEROLOGY
Tetanus/Diphtheria	Primary series of 3 Update every 10 years	#1 #2 #3 Last booster:	N/A
Pertussis	Single dose of Tdap in adulthood	#1	N/A
Polio (IPV)	Primary series of 3	#1 #2 #3	N/A
Varicella	If no immunity- 2 doses of Varivax required	#1 #2	Date: Results:
Measles Mumps Rubella	Primary series of 2 MMR  or Date of serology:	#1 #2	Measles: Mumps: Rubella:
Hepatitis B	Primary series of 3	#1 #2 #3	Date: Results:
TB Skin Test	2-step TB skin test with Negative results or Chest Xray if POS TBST	#1 #2 CXR	Result: Result: Result

I certify that as of this date, the student is free of any symptoms of active illness of any of the above reportable communicable diseases.

Physician's Signature:

\_\_\_\_\_

Date: \_\_\_\_\_

The signing physician acknowledges all of the above information as true to the best of their knowledge.

Physician's Stamp Below:

**NOTE: PHL SEROLOGY REPORT MUST BE ATTACHED**



**PRE-ENTRANCE HEALTH EXAMINATION**  
 (This page to be completed and signed by PHYSICIAN ONLY)

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: M / F  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_  
 Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y / N Contacts: Y / N Glasses Y / N Hearing: R \_\_\_\_\_ L \_\_\_\_\_

	Normal	Abnormal Findings	Comments
Head/ Neck			
Eyes/ Sclera/Pupils			
Ears			
Nose/Mouth/Throat			
Lymph Nodes			
Heart: Sounds/Rhythm			
Peripheral Vascular			
Lungs			
Chest contour			
Skin			
Abdomen			
Hernia			
Neck/Back/Spine: Alignment / ROM			
Neuro-musculo-skeletal Upper extremities Lower extremities			
Reflexes			
Balance + coordination			
Posture			
Psychosocial/Mental (any concerns)			

**PHYSICAL ABILITY CLEARANCE:**

In your opinion, is this individual capable of performing functions such as lifts/transfers/restraint protocols for all age groups/or carries safely? (circle one) Y / N

- Person is able to meet all physical demands of Paramedic program without restriction
- Person is able to meet the physical demands of the Paramedic program with the following restrictions/accommodations (specify):
  
- Person is NOT CLEARED as he/she is not able to meet all physical demands of the Paramedic program due to (specify):

I certify that this student IS / IS NOT physically *and* mentally fit to undertake the duties of his/her program.

Office Stamp (Name, Address, Phone Number)

\_\_\_\_\_  
 Signature of Physician

\_\_\_\_\_  
 Date of Exam