Student Name: _____ Seneca Student Number: _____

Medical Assessment Form
Pre-Placement Immunization Form

Completing this Form: Students are required to print this form and have it completed by a qualified Health Care Professional (HCP), such as a nurse, physician, physician assistant, or pharmacist. The documented items must be within the HCP's scope of practice. Under no circumstances should students complete any section of this form themselves. The completed form, along with any required attachments, must be submitted in accordance with the instructions outlined in the Pre-Placement Immunization Form.

Student Declaration:

1. I understand that the personal health information provided in this form will remain confidential and will be used by Synergy Gateway Verified Inc. to determine eligibility for clinical placement.

2. I confirm that the information provided in this form is accurate to the best of my knowledge.

3. I acknowledge that I have not completed any part of this form myself, except for this section.

4.I have read and understood the Synergy Gateway Verified Inc. disclaimer below:

By giving this form to a health care professional and by uploading this form on the Verified Platform, each student understands: (i) that all requirements are requested of the students is requested by their school and not by Verified to meet their placement standards. (ii) that Verified is not responsible for establishing which tests are relevant. (iii) that Verified is not involved in the selection of the health care professionals undertaking these tests and filling this form.

First Name: _____ Last Name: _____

Date of Birth (DD-MM-YYYY): _____-_____-_____

Student Name: _____ Seneca Student Number: _____

Section B. Health Care Professional (HCP) Information

Every HCP who completes any part of this form must complete this section. HCP initials verify the HCP has either provided the service or the HCP has reviewed the student's documented records; immunization documents based on estimated dates or verbal histories **must not** be counted. If more than two HCPs are involved with completing this form, print a second copy of page 2.

HCP Information or Office Stamp

HCP #1

Name: _____ Signature: _____

Designation: _____

Professional Identification Stamp

Date Completed (DD-MM-YYYY): _____-_____- _____

HCP #2

Name: _____ Signature: _____

Designation: _____

Professional Identification Stamp

Date Completed (DD-MM-YYYY): _____-_____- _____

Student Name: _____ Seneca Student Number: _____

1. Tetanus, Diphtheria, Pertussis:

- Document the **last** Tetanus/Diphtheria/Pertussis vaccination
- Last Tetanus/Diphtheria vaccination must be within the past **ten years**.
- Serology is not accepted for Tetanus, Diphtheria, and Polio.

Immunizations	**Vaccination Date** DD-MM-YYYY
Tetanus	
Diphtheria	
Pertussis	

2. Polio:

- Document the **last** Polio vaccine given

Immunization	**Vaccination Date** DD-MM-YYYY
Pertussis	

3. Measles, Mumps, Rubella and Varicella:

- ONE of the following items is required as evidence of immunity to **Measles, Mumps, Rubella and Varicella**:
- TWO doses of live Measles, Mumps, Rubella and Varicella vaccinations, given 28 days apart.
- Positive serology for Measles, Mumps, Rubella and Varicella antibodies (IgG).

Immunizations	**Vaccination 1** DD-MM-YYYY	**Vaccination 2** DD-MM-YYYY	**IgG Serology Test** DD-MM-YYYY	**Reactive**	**Non-Reactive**	**Indeterminate**
Measles				☐	☐	☐
Mumps				☐	☐	☐
Rubella				☐	☐	☐
Varicella				☐	☐	☐

Student Name: _____ Seneca Student Number: _____

4. Hepatitis B

- Documented serology results **(anti-HBs)** for Hepatitis B.
- Document proof of **primary series is required if serology does not show evidence of immunity**. Vaccinations must be one month between the first two doses and six months between the last two doses).
- If not immune after primary series, then begin secondary *series (if positive anti-HBs serology is present at any time the student does not need to complete the series).*
- Hepatitis B infection does not require immunizations documented.

Primary Series	**Vaccination Date** DD-MM-YYYY
Vaccination 1	
Vaccination 2	
Vaccination 3	

Serology	**Date** DD-MM-YYYY	**Reactive**	**Non-Reactive**	**Indeterminate**
Anti-HBs (antibody)		☐	☐	☐

Serology	**Date** DD-MM-YYYY	**Infection**	**No Infection**
HBsAG (antigen)		☐	☐

If not immune after Primary Series start Secondary Series

Secondary Series	**Vaccination Date** DD-MM-YYYY
Vaccination 1	
Vaccination 2	
Vaccination 3	

Serology	**Date** DD-MM-YYYY	**Reactive**	**Non-Reactive**	**Indeterminate**
Anti-HBs (antibody)		☐	☐	☐

Student Name: _____ Seneca Student Number: _____

5. Tuberculosis

- ONE of the following items is required as evidence for Tuberculosis
- Documented proof of a completed **2-Step TB Mantoux Skin Test** (7-28 days apart).
- If 2-Step Skin Test was completed more than 365 days ago an Annual 1-Step Skin Test is required. *(must document completed 2-Step to accept annual 1-Step).*
- Negative **Interferon-gamma Release Assay (IGRA)** test can be accepted
- History or a positive skin test or positive IGRA test must be accompanied with a Negative Chest Xray.
- Chest X-ray must be submitted with this form.

Two Step Skin Test	**Plant Date** DD-MM-YYYY	**Read Date** DD-MM-YYYY	**Induration in mm**
Step 1			
Step 2			

Single Step can only be accepted with proof of a previously completed two-step

Annual One Step Skin Test	**Plant Date** DD-MM-YYYY	**Read Date** DD-MM-YYYY	**Induration in mm**
Recent TST			

IGRA test can be accepted in lieu of a skin test

Serology	**Date** DD-MM-YYYY	**Negative**	**Positive**
IGRA		☐	☐

If a student has **a Positive TST** or s history of Positive TB, the student must complete a **Chest X-ray** dated subsequent to the positive TST or other positive TB history. A routine repeat or recent chest X-ray is not required unless there is a medical indication.

Chest X-ray	**Date of Chest X-ray** DD-MM-YYYY	**Results**	**Normal**	**Abnormal**
			☐	☐

6. Influenza

- Up to date seasonal influenza immunization.

Immunization	**Vaccination Date** DD-MM-YYYY
Influenza	
Influenza	