DOUGLASCOLLEGE

# Faculty of Health Sciences
# Department of Psychiatric Nursing
## MEDICAL & IMMUNIZATION FORM

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

**Email:** _____ **Phone Number:** _____

## INSTRUCTIONS TO APPLICANTS:

The Bachelor of Science in Psychiatric Nursing Program is academically, physically, and personally very challenging. A medical examination demonstrating fitness to practice and a current record of immunizations are required prior to admission. If an applicant has previously or is currently experiencing a physical/mental illness that may affect progress in the program, they may be asked to provide information regarding the impact this health concern may have on their ability to participate in rigorous academic courses and clinical practicums.

1. Students are responsible for maintaining their mental and physical health and their personal medical and hospital insurance throughout the program.
2. A medical examination is required to be submitted prior to admission to the program. Please have the Physical Examination section of the Medical Form completed by your physician/nurse practitioner.
3. An immunization record is required to be submitted prior to admission to the program along with supporting documentation. You are required to have had the following immunizations:
    i. Tetanus, Diphtheria and Pertussis: Basic immunization series with subsequent TD booster doses required every 10 years. It is recommended to have 1 adult dose of Pertussis. If proof of childhood immunizations is not available, an adult Tdap/TD series will be required.
    ii. Poliomyelitis: Basic immunization series plus a single booster dose after 10 years. If proof of childhood immunizations is not available, an adult Polio series will be required.
    iii. Measles/Mumps/Rubella (MMR): 2 doses required or immunity confirmed by serology.
    iv. Varicella (Chickenpox): 2 doses required or immunity confirmed by serology.
4. Hepatitis B: This vaccination series is **highly recommended** by provincial Health Authorities for those who may be exposed to blood or body fluids, or at increased risk of a sharps injury. At the present time this is not required for admission to the program. If you choose to have the vaccine series you will require two doses if given as part of routine immunizations in grade 6; otherwise three doses are necessary.
5. TB Skin Test: After being admitted to the program you will be required to have TB skin testing done within 6 months of your first clinical experience. (We will inform you of this date.) TB skin tests obtained prior to this date will not be accepted. In the event of a positive skin test, you will be required to submit a copy of a Chest X-Ray that is current within the last 12 months.
6. After being admitted to the program you will be required to have an annual Influenza Vaccine (or choose to wear a surgical mask at all times in the clinical practice setting during flu season) as required by the provincial Health Authorities.

## PROCESS FOR SUBMITTING MEDICAL AND IMMUNIZATION DOCUMENTS:

1. Please sign the consent below.
2. Have your physician/nurse practitioner complete the Physical Examination and Proof of Immunizations sections of the form.
3. It is the applicants' responsibility to ensure the Physical Examination, Proof of Immunizations Record, supporting immunization documentation and any medical requirements are submitted to the Office of the Registrar as soon as possible. **Please note: Incomplete forms will delay your application.**

## CONSENT:

I hereby authorize (give permission for) the examining physician/nurse practitioner to provide the Douglas College Registrar's Office and the Department of Psychiatric Nursing with any information and/or opinions regarding my health.

_____ _____

Signature Date

**DOUGLAS**COLLEGE
PO Box 2503 New Westminster BC
Canada V3L 5B2

New Westminster and Coquitlam
douglascollege.ca
604 527 5400

# INSTRUCTIONS TO THE EXAMINING PHYSICIAN/NURSE PRACTITIONER

The physical examination form is a confidential document that is required by the Department of Psychiatric Nursing for admission to the program. It is used to facilitate student success and determine fitness to practice in health care settings. Please return the Physical Examination Record by mail to the office of the Registrar or have the applicant deliver it themselves to the Office of the Registrar.

**Please ensure all information requested is complete with no questions left blank.**
We will need to contact you if the form is incomplete and this will delay the applicant's application. Thank you for your assistance.

Mail to: DOUGLAS COLLEGE
Admissions
Coquitlam Campus
Office of the Registrar
1250 Pinetree Way Coquitlam, BC
V3B 7X3

# PHYSICAL EXAMINATION

**(*To be completed and signed by the Examining Physician/Nurse Practitioner)***

***Please complete all sections and do not leave any blank questions as this will delay the admissions process.***

**The information provided below is confidential and will be used for admission purposes to determine fitness to practice and to support student success.**

**NAME OF APPLICANT:** _____

**ANY KNOWN ALLERGIES:** _____

| Height (cm): | Weight (kg): |
|---|---|

**REVIEW OF SYSTEMS:**

**Musculoskeletal System:**

| Back Abnormalities: |
|---|
| Joint Abnormalities: |

**Cardiovascular System:**

| Heart: | |
|---|---|
| Blood Pressure: | Pulse: |

| **Central Nervous System:** |
|---|
| **Respiratory System:** |
| **Gastrointestinal System:** |
| **Dermatological System:** |
| **Genitourinary System:** |

**SPECIAL SENSES:**

| Vision : Right eye /20 | Left eye /20 | Wears Corrective Lenses? Yes No |
|---|---|---|
| Hearing: | | |

**PHYSICAL EXAMINATION:** ***To be completed and by signed by the Examining Physician/Nurse Practitioner.***

***Please complete all sections and do not leave any blank questions as this will delay the Admissions process.***

How long have you known this applicant? _____

Please comment on any irregularities or chronic conditions that are likely to interfere with the applicant's ability to function as a Registered Psychiatric Nurse.

_____

_____

Is this applicant on medications at this time (other than BCP)? If yes, please list.

_____

**MENTAL HEALTH STATUS:** Please comment on the past and present emotional/mental health of this applicant, i.e.: emotional instability, anxiety, depression, psychosis.

_____

_____

_____

**DRUG/ALCOHOL USE:** Please comment on any past or present drug/alcohol related issues.

_____

_____

_____

**MENTAL HEALTH TREATMENT:** Has this applicant had active treatment (including hospitalization) during the past two years? If yes, please explain.

_____

_____

**GENERAL HEALTH:** Please comment on the applicant's general health.

_____

_____

Given the findings, would the applicant be able to cope with the heavy academic and vocational stresses of a psychiatric nursing program and the complexities of providing patient care in psychiatric nursing practice? Please explain.

_____

_____

**EXAMINED BY:**_____ **DATE:** _____

**PHYSICIAN'S/NURSE PRACTITIONER'S NAME, ADDRESS, PHONE & FAX NUMBER (printed or stamped)**

DOUGLAS COLLEGE

***Please PRINT clearly***

# Faculty of Health Sciences
# Department of Psychiatric Nursing
# IMMUNIZATION RECORD

**FULL NAME:** _____
Surname First Name Second Name

**STUDENT NUMBER:** _____

**Your Permanent Mailing Address**

Street _____

City _____ Province _____

Postal Code _____

Telephone _____

Cell _____

Email _____

**Local Person to Contact in the Case of Emergency**

Name _____

Street _____

City _____ Province _____

Postal Code _____

Telephone/Cell _____

Email _____

**DEPARTMENT REQUIREMENTS**

Participation in clinical experience requires assessment of your immunization status. You are required to meet Health Authority Requirements for immunizations for students in practice settings. If Health Authority immunization requirements are not met you may not have access to clinical agencies and, subsequently, the inability to complete required clinical courses which would prevent your progression in the program.

**INFORMATION**

Immunizations can be obtained from your Family Physician, Walk-in Clinic Physician, local Public Health Unit, Nurse Practitioner or Travel Clinic.

***Ensure your Immunization Record is complete, dated, and signed to avoid delays in processing your application.***

**PROOF OF IMMUNIZATION**

You are responsible to **keep a copy of your immunization record** as you may be required to provide proof of immunization when in a practice setting. **Copies of all original immunization and/or lab serology documents need to be submitted along with the completed Immunization Record.**

**CONSENT (to be signed by the Applicant)**

I hereby authorize (give permission to) my Family Physician/Nurse Practitioner or Walk-in Clinic Physician/Nurse Practitioner to provide Douglas College Faculty of Health Sciences any information regarding my immunizations.

**Applicant's Signature:** _____ **Date:** _____

**This record must be completed in full and returned by the deadline date indicated on your acceptance letter to:**
**DOUGLAS COLLEGE**
Coquitlam Campus
Office of the Registrar
1250 Pinetree Way
Coquitlam, BC V3B 7X3

**PROOF OF IMMUNIZATIONS**

*(to be completed and signed by the Examining Physician/Nurse Practitioner)*

**KEEP A COPY OF THIS FORM FOR YOUR RECORDS**

_____ _____

**Student Name (Please Print)** **Student Number**

## To the Applicant:

For admission, you are required to complete the following immunizations. Immunizations are required for your own protection and the protection of patients and families you care for as a student. If Health Authority immunization requirements are not met you may not have access to clinical agencies and, subsequently, the inability to complete required clinical courses which would prevent your progression in the program.

***Copies of all original immunization and/or lab serology documents must be submitted along with the completed Immunization Record.***

**1. TETANUS-DIPHTHERIA-PERTUSSIS (Tdap) Vaccine**

**Category A:**
**Applicants who have received the Tetanus-Diphtheria-Pertussis primary series and booster immunizations and who can provide ALL documentation showing this:**

Primary Series and booster doses documents attached: Yes _____ No _____

TD (Tetanus/Diphtheria) booster required within the past 10 years (this may be combined with a Tdap vaccine as 1 adult dose of Pertussis is recommended.)

Date received (DD/MM/YYRR) _____Health Care Practitioner Signature:_____

**Category B:**
**Applicants who did not receive their primary series with booster doses of Tdap or do not have access to their immunization documents must have the series done as an adult (only one dose Pertussis required as an adult):**

1st Dose Tdap: Date received (DD/MM/YYRR): _____Health Care Practitioner Signature: _____
2nd Dose TD: Date received (DD/MM/YYRR): _____Health Care Practitioner Signature: _____
3rd Dose TD: Date received (DD/MM/YYRR): _____Health Care Practitioner Signature: _____

**2. POLIO Vaccine**

**Category A:**
**Applicants who have received the Polio primary series immunizations and can provide ALL documentation showing this:**

Primary Polio Series documents attached: Yes _____ No _____

Polio booster (required 10 years after primary series):

Date received (DD/MM/YYRR): _____Health Care Practitioner Signature:_____

**Category B:**
**Applicants who did not receive their primary series of Polio or do not have access to their immunization documents must have the series done as an adult:**

1st Dose Polio: Date received (DD/MM/YYRR): _____Health Care Practitioner Signature: _____
2nd Dose Polio: Date received (DD/MM/YYRR): _____Health Care Practitioner Signature: _____
3rd Dose Polio: Date received (DD/MM/YYRR): _____HealthCare Practitioner Signature: _____

**3. MEASLES-MUMPS-RUBELLA (MMR) Vaccine**

**Category A:**
**Applicants who have received 2 MMR immunizations and who can provide ALL documentation showing this:**

MMR Series documents attached: Yes _____No _____

**Category B:**
**Applicants who did not receive their MMR series or do not have access to their immunization documents must have the series done as an adult:**

1st Dose MMR: Date received (DD/MM/YYRR):_____ Health Care Practitioner Signature: _____
2nd Dose MMR: Date received (DD/MM/YYRR):_____Health Care Practitioner Signature: _____

**Category C:**
**Applicants who have serology confirming immunity to MMR:**

Serology documents attached: Yes _____ No _____

**4. VARICELLA (CHICKENPOX) Vaccine**

**Category A:**
**Applicants who have received 2 Varicella immunizations and who can provide ALL documentation showing this:**

Varicella Series documents attached: Yes _____ No _____

**Category B:**
**Applicants who did not receive their Varicella series or do not have access to their immunization documents must have the series done as an adult:**

1st Varicella Dose: Date received (DD/MM/YYRR):_____Health Care Practitioner Signature: _____
2nd Varicella Dose: Date received (DD/MM/YYRR):_____ Health Care Practitioner Signature: _____

**Category C:**
**Applicants who have serology confirming immunity to Varicella:**

Serology documents attached: Yes _____ No _____

The following immunization series is **highly recommended** for all individuals who may be exposed to blood or body fluids, or are at increased risk of a sharps injury:

**HEPATITIS B Vaccine**

**Category A:**
**Two doses if given as part of routine immunizations in grade 6; otherwise three doses:**

1st Dose Hepatitis B: Date received (DD/MM/YYRR): _____Health Care Practitioner Signature _____
2nd Dose Hepatitis B: Date received (DD/MM/YYRR): _____Health Care Practitioner Signature: _____
3rd Dose Hepatitis B: Date received (DD/MM/YYRR): _____Health Care Practitioner Signature: _____

**Category B:**
**Applicants who have serology confirming immunity to Hepatitis B:**

Serology documents attached: Yes _____ No _____

**PHYSICIAN'S/NURSE PRACTITIONER'S NAME, ADDRESS, PHONE & FAX NUMBER (printed or stamped)**