NORTH COUNTRY COMMUNITY COLLEGE
THE STATE UNIVERSITY OF NEW YORK
RADIOLOGIC TECHNOLOGY PROGRAM

Health Requirements for Radiologic Technology Students

In addition to the two (2) State Mandated MMR (measles/mumps/rubella) immunizations and the Meningitis documentation required by Health Records at NCCC, there are other program requirements that must be submitted to the Radiologic Technology office.

- *Information needed the first day of classes are highlighted in yellow below.*
- *If the boxes are not highlighted in yellow, the information is **not needed until later in the semester**.*

☐ **COVID-19 Vaccination:** COVID-19 vaccinations, including the booster, are currently a requirement to attend on campus courses on any SUNY campus. Additionally, vaccination for COVID-19 is currently a requirement to attend clinical rotations at **all** Radiologic Technology clinical locations.

☐ **Health Report (physical):** Copy below. This form must be ***COMPLETELY*** filled out by you and by a health care professional. NOTE: All dates (including date of physical exam) must be AFTER July 4th (within six months of the first clinical rotation). **Depending on the clinical sites that you attend, you may be required to submit an updated physical every six months**. Please make sure that *your* signature is on the second page and the health care professional's signature and office information are on pages 2 (for the PPD/TB Skin Test) and on page 3 (for the physical examination).

☐ **Tuberculin Skin Test (PPD):** The date of the Tuberculin skin test must be within the last year. Please have your health care professional complete the appropriate section on page 2 of the health form (enclosed) or submit the information on the letterhead or prescription pad from the health care professional's office. **Depending on the clinical sites that you attend, you may be required to submit a Two-Step Test *or* a Second PPD.**

☐ **OSHA Respirator Evaluation:** Copy below. Questions 1-9 on this form must be ***COMPLETELY*** filled out by you and then the **document must be reviewed and signed by a physician.** If the facility is unable to provide the fit test at that time, the fit test will be completed at a later date at NCCC.

☐ **Tetanus Shot (Tdap):** NCCC and clinical affiliates are requiring proof of a tetanus shot within the last ten years.

☐ **Varicella/Zoster & Hepatitis B Information Sheets:** Copies below. Please sign and return them to this office. **As noted on the document, you will need to submit either proof of Varicella vaccination or a positive Varicella titer.** In lieu of the Hep B Information Sheet, you may provide proof of positive Hep B titer. Proof of the Hep B series alone is not sufficient to meet this requirement.

☐ **Seasonal flu vaccination:** Due October. NCCC and its clinical affiliates require that you obtain and provide proof of the seasonal flu vaccination. Do **NOT** obtain this vaccination prior to September to ensure appropriate strains are included.

☐ **Valid CPR card for Professional Rescuer or Healthcare Provider:** Due December. Please see the enclosed information sheets regarding acceptable CPR courses. The date of the certification must be within the past year. If need be, you have the opportunity to attend CPR in the Fall semester at NCCC prior to the due date. ***NOTE that the CPR certification must be for infant, child and adult with AED and BVM, or it will not be acceptable.*** On-line courses without practical demonstration are NOT acceptable.

☐ **Student Professional Liability Insurance:** Due December. All students who have been admitted to the AAS Radiologic Technology program will be required to provide proof of student professional liability insurance and maintain coverage throughout the course of the program. Further information on obtaining this insurance will be covered at the start of the Fall semester.

PLEASE DO NOT PROCRASTINATE!
TAKE CARE OF THESE REQUIREMENTS AND SUBMIT THEM BEFORE THE REQUIRED DEADLINES!
FAILURE TO COMPLY WILL RESULT IN REMOVAL FROM THE RADIOLOGIC TECHNOLOGY PROGRAM.

NORTH COUNTRY COMMUNITY COLLEGE

THE STATE UNIVERSITY OF NEW YORK

Name: _____, _____, _____
Last Name First Name M.I.

PHYSICAL HEALTH REPORT

This health report and physician's evaluation form the basis of the employee's and student's health record for specialized curricula. This information is strictly confidential, and in no way influences the student's or employee's standing at the College.

RADIOLOGIC TECHNOLOGY STUDENTS/FACULTY

Required to have an annual physical examination including Tuberculin Skin Test (PPD) and must complete the "Radiologic Technology" section of this health report.

New York State Public Health Law, Section 2165, requires proof of immunity to measles, mumps and rubella and proof or declination of the meningitis vaccination. This law is mandatory for ALL college students born in 1957 or later and registered for six (6) credit hours or more. (See separate Student Immunization Record Form.*)*

INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL.

➔ **PHYSICIANS**: Complete Part III and sign by the bold arrows ➔

RETURN COMPLETED HEALTH EVALUATION IN "CONFIDENTIAL ENVELOPE"

NORTH COUNTRY COMMUNITY COLLEGE
Radiologic Technology Department
23 Santanoni Avenue, PO Box 89
Saranac Lake, NY 12983

Rev. 4/14 BL

CONFIDENTIAL **I. PERSONAL HEALTH REPORT** **CONFIDENTIAL**

To be completed by Student/Faculty

Year_____ ☐ Fall ☐ Spring Date of Birth: _____

Name _____

Home Phone E-mail Address

Home Address _____

& Street City State Zip

Address while attending NCCC **(if same as above, write "SAME"):**

_____

& Street City State Zip

Person to Notify in Case of Emergency:

_____

Day Phone Evening Phone Relationship

Address _____

& Street City State Zip

Family Physician: **(If none please write in none)** _____

Name Phone Number

Physician's Address: _____

& Street City State Zip

CONFIDENTIAL **II. PERSONAL HISTORY** **CONFIDENTIAL**

Place an "X" in the appropriate box (es):

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/shortness of breath
- ☐ Back Problems
- ☐ Bleeding Disorders
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Bowel Problems
- ☐ Broken bones/joint dislocations
- ☐ Chest pains on exertion or deep breathing
- ☐ Chronic cough/bronchitis/ bloody sputum
- ☐ Chronic pain in
  - ☐ neck ☐ arms
  - ☐ back ☐ legs
  - ☐ shoulders ☐ other
- ☐ Chronic skin problems (rash, infection)
- ☐ Concussion (within last yr)
- ☐ Continuing use of alcohol, drugs, or medicines
- ☐ Depression
- ☐ Diarrhea (recurrent)
- ☐ Difficulty urinating/burning or pain on urination/ frequency in urinating.
- ☐ Digestive Problems
- ☐ Dizziness/Fainting
- ☐ Ear Trouble
- ☐ Eye Trouble
  - ☐ Glasses
  - ☐ Contact Lenses
- ☐ Food Intolerances
- ☐ Frequent nausea or vomiting
- ☐ Headaches/ migraines (recurrent)
- ☐ Hearing Problems
  - ☐ Hearing aid
- ☐ Heart Defect/Disease
- ☐ Heartburn/GERD
- ☐ Hepatitis
- ☐ Hernia
- ☐ History of diabetes
- ☐ IBS
- ☐ Immune System Disorder
- ☐ Joint disease (injury)
  - ☐ pain
  - ☐ swelling } w/o injury
  - ☐ stiffness
- ☐ Kidney Disease
  - ☐ Infection
  - ☐ Stones
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Mental Illness or disorder
- ☐ Motion Sickness
- ☐ Pneumonia
- ☐ Problems w/ teeth
  - ☐ dentures
  - ☐ bridge
- ☐ Serious sprains/weakness of muscles
- ☐ Seizures
- ☐ Severe injury to head/ chest/internal organs
- ☐ Severe menstrual cramps/bleeding
- ☐ Sinusitis
- ☐ Sore Throat (frequent)
- ☐ Thyroid trouble
- ☐ Traumatic Brain Injury
- ☐ Tuberculosis
- ☐ Ulcerative Colitis / Crohn's
- ☐ Other (specify):

_____

_____

If checked <u>any of the above</u>, please explain below. Be specific. Use additional paper if necessary.

_____

_____

_____

Please list any allergies to foods, drugs, etc._____

_____

Do you take any medications regularly? ☐Yes ☐No If "Yes", please list drug(s) and dosage(s) _____

_____

Please list any serious injuries, illnesses, fractures, dislocations and surgery:_____

_____

(PERSONAL HISTORY CONTINUED ON NEXT PAGE)

Do you have any disability or impairment of which we should be aware? ☐Yes ☐No
If "Yes", please explain: _____

_____

Are you currently receiving treatment at a clinic or by a physician (other than regular checkups)? ☐Yes ☐No
If "Yes", please explain: _____

_____

Are you or have you ever been under the care of a psychologist, psychiatrist or psychiatric clinic? ☐Yes ☐No
If "Yes", please explain: _____

When was your last tetanus booster? _____

RELEASE AUTHORIZATION

CONFIDENTIAL NURSING and RADIOLOGIC TECHNOLOGY STUDENTS / FACULTY ONLY CONFIDENTIAL

I affirm that I have completed Sections I and II of the Health Report completely and accurately. By signing this form, I hereby authorize NCCC to disclose, as needed, any and all of my health-related records to: clinical and community facilities and agencies that I will be assigned to; College program faculty, staff, and administrators who have legitimate educational interest in this information; and emergency and other medical personnel in a medical or emergency situation. I also assume full responsibility for my participation in clinical and community experiences, releasing the College from any and all liability. I further understand that if at any time during the semester my health conditions change or I am involved in an accident that affects my ability to provide care, I will notify NCCC Program Faculty immediately.

_____ _____

Name (Please Print) Signature Date

CONFIDENTIAL III. PHYSICAL EXAMINATION CONFIDENTIAL

1. Tuberculin Skin Test (PPD) every 12 months. Date: Administered_____

Date Read_____ Results _____

(Must be read in mm induration, not simply as negative or positive)

➔ **SIGNATURE AND TITLE OF HEALTH CARE PROFESSIONAL READING THE PPD (MANTOUX):**

_____ _____ _____

Signature/Title Date Name *(please print)*

Address_____

Phone Number (with area code) _____

If positive, a chest x-ray must be provided Date: _____ Results: _____

Did patient have treatment for the positive skin test? ☐Yes ☐No

Drug:_____ Date started:_____ Date completed:_____

CONFIDENTIAL **V. Physician's Evaluation** **CONFIDENTIAL**

Please print or type all information. Thank you.

Name of student: _____ Date of Birth:_____ (mm/dd/yyyy)

★ PHYSICIANS: Please complete **ALL** sections of this form. **It cannot be accepted unless completed.**

Sex: ☐Male ☐Female	Height:	Weight:	Blood Pressure:

CLINICAL EXAMINATION Check each item in proper column.	**NORMAL**	**ABNORMAL**	**NOTE:** Give details of each abnormality. Enter N.E. if not evaluated.
Metabolic Endocrine System			
Musculoskeletal System			
Neuropsychiatric System			
Abdomen / Pelvic			
Respiratory			
Cardiovascular System			
Gastrointestinal System			
Head			
Neck			
Eyes			
Ears			
Nose			
Throat & Teeth			
Breasts			
Genito-Urinary			
Extremities			
Skin			

RECOMMENDED:

Lab tests at Physician's discretion:	***Hemoglobin or Hematocrit:***	***Urinalysis:***	***Other:***

Is this student able to participate in all physical activity to include one or more of the following: Clinical Hospital Experience, Extended Wilderness Trips and Camping Experiences, Physical Education, Intramural or Intercollegiate Sports Competition.

☐Yes ☐No If "No" what activities are to be eliminated?

_____

Is there (or has there ever been) evidence of anxiety or emotional instability?

☐Yes ☐No If so, please indicate how the College may be of help to this student.

_____

After considering the history and physical examination, what is your professional opinion of this applicant's ability to meet the physical and emotional demands of college life?

_____

Do you recommend further investigation or treatment?

☐Yes ☐No If "Yes" please explain.

_____

NAME OF EXAMINING PHYSICIAN (PLEASE PRINT)		PHONE	
STREET	CITY	STATE	ZIP
➔ SIGNATURE		DATE	

NORTH COUNTRY COMMUNITY COLLEGE
THE STATE UNIVERSITY OF NEW YORK

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Today's Date:_____ **Your Name:** _____

Your Height:_____Ft._____In. **Your Weight:**_____Lbs. **Your Job Title:** **Student Radiographer**

PART A -- Questions 1 through 9 below must be answered by every individual who has been selected to use any type of respirator (please check "yes" or "no").

1.	**Do you currently smoke tobacco, or have you smoked tobacco in the last month?**	☐ **Yes**	☐ **No**
2.	**Have you ever had any of the following conditions?**		
a.	Seizures (fits) ……..	☐ **Yes**	☐ **No**
b.	Diabetes (sugar disease) ……..	☐ **Yes**	☐ **No**
c.	Allergic reactions that interfere with your breathing ……..……..	☐ **Yes**	☐ **No**
d.	Claustrophobia (fear of closed-in places) …….	☐ **Yes**	☐ **No**
e.	Trouble smelling odors ……	☐ **Yes**	☐ **No**
3.	**Have you ever had any of the following pulmonary or lung problems?**		
a.	Asbestosis ……	☐ **Yes**	☐ **No**
b.	Asthma ……..……..	☐ **Yes**	☐ **No**
c.	Chronic bronchitis ……	☐ **Yes**	☐ **No**
d.	Emphysema ……..	☐ **Yes**	☐ **No**
e.	Pneumonia ……..	☐ **Yes**	☐ **No**
f.	Tuberculosis ……..	☐ **Yes**	☐ **No**
g.	Silicosis ……..……..	☐ **Yes**	☐ **No**
h.	Pneumothorax (collapsed lung) ……...	☐ **Yes**	☐ **No**
i.	Lung cancer ……..…	☐ **Yes**	☐ **No**
j.	Broken ribs ……..…	☐ **Yes**	☐ **No**
k.	Any chest injuries or surgeries ……..…	☐ **Yes**	☐ **No**
l.	Any other lung problem that you've been told about ……..……	☐ **Yes**	☐ **No**
4.	**Do you currently have any of the following symptoms of pulmonary or lung illness?**		
a.	Shortness of breath ……..……..	☐ **Yes**	☐ **No**
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline……	☐ **Yes**	☐ **No**
c.	Shortness of breath when walking with other people at an ordinary pace on level ground…….....	☐ **Yes**	☐ **No**
d.	Have to stop for breath when walking at your own pace on level ground…….….....	☐ **Yes**	☐ **No**
e.	Shortness of breath when washing or dressing yourself……..	☐ **Yes**	☐ **No**
f.	Shortness of breath that interferes with your job……. …….....	☐ **Yes**	☐ **No**
g.	Coughing that produces phlegm (thick sputum)…….. ……...	☐ **Yes**	☐ **No**
h.	Coughing that wakes you early in the morning…….....	☐ **Yes**	☐ **No**
i.	Coughing that occurs when you are lying down……..…..	☐ **Yes**	☐ **No**
j.	Coughing up blood in the last month……..…....	☐ **Yes**	☐ **No**
k.	Wheezing…….....	☐ **Yes**	☐ **No**
l.	Wheezing that interferes with your job……..…...	☐ **Yes**	☐ **No**
m.	Chest pain when you breathe deeply……..…..	☐ **Yes**	☐ **No**
n.	Any other symptoms that you think may be related to lung problems……..….....	☐ **Yes**	☐ **No**
5.	**Have you *ever* had any of the following cardiovascular or heart problems?**		
a.	Heart attack…….....	☐ **Yes**	☐ **No**
b.	Stroke ……..……..	☐ **Yes**	☐ **No**
c.	Angina ……..……	☐ **Yes**	☐ **No**

d. Heart failure…… ☐ **Yes** ☐ **No**
e. Swelling in your legs or feet (not caused by walking) …… ☐ **Yes** ☐ **No**
f. Heart arrhythmia (heart beating irregularly) …… ☐ **Yes** ☐ **No**
g. High blood pressure…… ☐ **Yes** ☐ **No**
h. Any other heart problem that you've been told about…… ☐ **Yes** ☐ **No**

6. **Have you *ever* had any of the following cardiovascular or heart symptoms?**
a. Frequent pain or tightness in your chest…… ☐ **Yes** ☐ **No**
b. Pain or tightness in your chest during physical activity…… ☐ **Yes** ☐ **No**
c. Pain or tightness in your chest that interferes with your job…… ☐ **Yes** ☐ **No**
d. In the past two years, have you noticed your heart skipping or missing a beat …… ☐ **Yes** ☐ **No**
e. Heartburn or indigestion that is not related to eating …… ☐ **Yes** ☐ **No**
f. Any other symptoms that you think may be related to heart or circulation problems…… ☐ **Yes** ☐ **No**

7. **Do you *currently* take a medication for any of the following problems?**
a. Breathing or lung problems…… ☐ **Yes** ☐ **No**
b. Heart trouble…… ☐ **Yes** ☐ **No**
c. Blood pressure …… ☐ **Yes** ☐ **No**
d. Seizures (fits)…… ☐ **Yes** ☐ **No**

8. **If you've used a respirator, have you ever had any of the following problems? (<u>If you've never used a respirator, check the following box and go to question 9</u>.)**
☐ Never used a respirator before.
a. Eye irritation…… ☐ **Yes** ☐ **No**
b. Skin allergies or rashes …… ☐ **Yes** ☐ **No**
c. Anxiety …… ☐ **Yes** ☐ **No**
d. General weakness or fatigue…… ☐ **Yes** ☐ **No**
e. Any other problem that interferes with your use of a respirator …… ☐ **Yes** ☐ **No**

9. **Would you like to talk to the health-care professional who will review this questionnaire about your answers to this questionnaire?** …… ☐ **Yes** ☐ **No**

Reviewed by:

NAME OF REVIEWING PHYSICIAN (PLEASE PRINT)		**PHONE**	
STREET	**CITY**	**STATE**	**ZIP**
➔ **SIGNATURE**		**DATE**	

Fit Test

Test Type: ☐ Qualitative (Bitrex/Saccharin) ☐ Quantitative (Portacount)

Respirator Type: N95 Disposable Particulate Filter Respirator

☐ Halyard/KC Orange "Duckbill" ☐ 3M Round (White/Teal) ☐ ENVO ☐ BYD-Teal ☐ Other_____

☐ Small ☐ Medium ☐ Regular ☐ One size

Sensitivity Test: ☐ 10 ☐ 20 ☐ 30 ☐ >30 unable to test

Fit test: ☐ 5 ☐ 10 ☐ 15

(Initial as per sensitivity test, then ½ number every 30 seconds for duration of test)

☐ Pass- no taste of bitrex/saccharin ☐ Fail-tasted bitrex/saccharin (try alternate mask style)

If N95 Fit Test Failure, use of Hepa-Mate 12 is required. Hepa-Mate 12 education provided? ☐ Yes ☐ No

Fit Tester Signature: _____Date: _____

Employee Signature: _____Date: _____

NORTH COUNTRY COMMUNITY COLLEGE
Radiologic Technology Program

TO: Radiologic Technology Students

Subject: **Varicella (Chicken Pox) and Zoster (Shingles)**

☐ I have had a Varicella Titer (please submit evidence of titer with this form.)

OR

☐ I have received the immunization series (2 shots) for varicella/chickenpox (please submit appropriate evidence of immunizations with this form).

I understand that if I do not have immunity to Varicella, I could contract the disease in the form of Shingles (Zoster) or Chicken Pox (Varicella). I also understand that if I do contract either disease, I could spread it to patients (particularly those with a decrease in immunity) unknowingly during the prodromal stage of the disease which may run from 10 days post exposure to the end of the incubation period of 21 days post exposure.

Therefore, I understand that if I do not have a positive Varicella titer, I would be professionally negligent in reporting to a clinical area in the event that I do become exposed to either disease.

I further understand that if I do contract Varicella or Zoster, I will not return to patient care until all lesions have dried and crusted.

MY DATED SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT, IF I DO NOT HAVE A POSITIVE TITER FOR VARICELLA OR AM NOT POSITIVE THAT I HAVE IMMUNITY TO VARICELLA, I WILL COMPLY WITH THE ABOVE POLICY.

Print Name: _____

Signature: _____ Date: _____

RETURN SIGNED FORM TO THE RADIOLOGIC TECHNOLOGY OFFICE

over ➲

8. PERSONNEL EXPOSED TO VARICELLA OR ZOSTER

   a. After exposure to varicella (chickenpox) or zoster (shingles) personnel not known to be immune to varicella (by history or serology) should be excluded from work beginning on the tenth day after exposure and remain away from work for the maximum incubation period of varicella (21 days).
   CATEGORY I

   b. Personnel who have onset of varicella should be excluded from work at least until all lesions have dried and crusted.

These suggestions are not meant to restrict hospitals from using additional precautions.

NORTH COUNTRY COMMUNITY COLLEGE

Radiologic Technology Program

TO: Radiologic Technology Students

Hepatitis B Information Sheet

I understand that, due to my attendance in clinical experience, exposure to blood or other potentially infectious materials is a very real possibility. As a result of a possible exposure, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. North Country Community College has recommended that I receive the series of Hepatitis B vaccinations as an effective way of protecting myself from acquiring this infection. I understand that it is, however, my choice to make and that whatever I decide will not affect my status at NCCC.

I further understand that if I make the decision to decline the series of HBV vaccinations, I continue to be at risk of acquiring Hepatitis B, a serious disease. I also understand that my risk may be decreased by maintaining certain behaviors in the clinical setting and that these behaviors will be taught to me prior to entry into the clinical practicum. I further understand that learning these behaviors and maintaining these techniques and behaviors in the clinical setting are primarily my responsibility. I fully understand, however, that total protection can only be achieved by having active immunity for Hepatitis B.

In the event that I choose not to receive the series of HBV vaccinations, I take full responsibility for my decision and will not hold NCCC or the clinical agency in which I learn and practice my skills responsible if I should acquire the Hepatitis B virus. If I do choose to receive the series of HBV vaccinations, I understand that I (not NCCC) am responsible for any and all expenses incurred as a result of my decision to receive these vaccinations and/or titers.

To be permitted to enter a clinical area, all students must read, date and sign this form. For individuals deciding to receive the series of HBV vaccinations, guidelines are printed on the reverse side of this sheet to help explain and facilitate the vaccination process.

MY DATED SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE PRECEDING INFORMATION ABOUT ***HEPATITIS B*** AS IT RELATES TO MY STATUS AS A STUDENT IN THE RADIOLOGIC TECHNOLOGY PROGRAM, THAT I MUST MAKE A DECISION TO**:**

- ☐ **SUBMIT A COPY** OF THE SERIES OF HBV VACCINATIONS **OR,**
- ☐ **SUBMIT A COPY** OF LAB RESULTS SHOWING A POSITIVE TITER **OR,**
- ☐ **DECLINE** THE SERIES OF HBV VACCINATIONS

_____

Print Name

_____ _____

Signature Date

8. CONTROL OF HEPATITIS INFECTION

a. Personnel who are suspected of being infected with hepatitis A virus (HAV) should not take care of patients until 7 days after the onset of jaundice. CATEGORY III

b. Screening for evidence of prior infections with hepatitis B virus (HBV) in personnel who work in dialysis centers or other high-risk areas should be done only when needed to institute appropriate control measures. CATEGORY I

c. Personnel who are known carries HbsAg should be counseled about precautions to minimize their risk of infecting others. CATEGORY I

d. 1) Personnel who have no exudative lesions on the hands and who are acutely infected with HBV, are known to be carries of HbsAg, or have hepatitis non A/non B (NANB) should not be restricted from patient-care responsibilities, unless there is evidence of disease transmission. CATEGORY I

2) Personnel who have no exudative lesions on the hands and who are acutely infected with HBV, are known to be carries of HbsAg, or have hepatitis NANB should wear gloves for procedures that involve trauma to tissues or direct contact with mucous membranes or non-intact skin. CATEGORY II

e. Personnel with exudative lesions on the hands who are HbsAg-positive should either wear gloves for all direct patient contact and when handling equipment that will touch mucous membranes or non-intact skin or abstain from all direct patient care. CATEGORY I

f. Dental personnel should consider routine use of gloves, masks, and protective eyewear when performing dental procedures. CATEGORY III

These suggestions are not meant to restrict hospitals from using additional precautions.