Student Name________________________________ M00#________________________________

Health Services Department
Radiology Technician Program

Purpose

Completion of this packet is required as part of the admission process. The information you provide will be evaluated against the technical standards that have been validated as essential for participation in the program.

Students

- Please complete Section 1, 2 and 3 of this career packet. Your name and student ID number (M00 #) must be on each page in case the pages become separated. These are fillable PDF forms. You can use your computer to fill in the student fields and then print it to sign and date using ink or the forms can be completed in ink.
- Completion of this entire packet (including vaccines or waivers, tuberculosis screening and proof of a physical exam done within the past year) is required from each student before submission.
- Please monitor your MCC student email account, as an RN will review your health packet and contact you via student email to let you know if anything else is needed. This process can take up to 72 hours.

Healthcare Providers

- Please ensure that the PPD and all of the immunization requirements Section 4 have been met.
- Be sure the four questions on the top of the physical form are completed and signed by the provider. This is a NYS Department of Health requirement for students entering a health career program.

Nondiscrimination Statement: Monroe Community College prohibits discrimination based on race, color, religion, sex, sexual orientation, pregnancy, familial status, gender identity or expression, age, genetic information, national or ethnic origin, physical or mental disability, marital status, veteran status, domestic violence victim status, socioeconomic status, criminal conviction, or any other characteristic or status protected by state or federal laws or College policy in admissions, employment and treatment of students and employees, or in any aspect of the business of the College.

Health Services
MONROE COMMUNITY COLLEGE

COVID-19 Screening Form

Last Name: ___________________________ First Name: _____________________ MI: ________________

M#: ____________________ Date of Birth: ___________________ Age: ________

Cell Phone: ___________________________ Email: ____

Gender: Male Female Student Employee

Please complete this form to assess your potential exposure / possession of COVID-19 and other illnesses.

Are you currently free from illness? Yes No

Do you have: heart disease Yes No

lung disease Yes No

kidney disease Yes No

diabetes Yes No

autoimmune disease Yes No

During your time away from Monroe Community College, did you experience, or are you currently experiencing any of the following:

Symptoms: *Check all that apply*

Fever Loss of Smell Diarrhea Body Chills Sore Throat

Upset stomach Extreme Level of Fatigue Loss of Taste Cough

Body / Muscle Aches Pain/Difficulty Breathing Shortness of Breath

- 2-14 days prior to experiencing these symptoms, did you experience a suspected exposure to COVID-19?

  Yes No

- Have you had any direct contact with anyone who lives in or has visited a place where COVID-19 is spreading and/or is an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?

  Yes No

- Have you had any direct contact with someone that has a suspected or lab confirmed case of COVID-19?

  Yes No

- During your time away from INSTITUTION, did you self-quarantine due to suspected symptoms or exposure of COVID-19?

  Yes No

- During your time away from INSTITUTION, have you been living in, or have visited an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?

  Yes No

- Have you previously been or are you currently diagnosed with COVID-19?

Yes No Date of Diagnosis: __________

Do you have medical documentation to support your diagnosis and treatment of COVID-19?

Yes No

Physician Name: Phone: _______________

Physician Address: ____

Please list any countries/states/cities you have traveled to since March 15th, 2020 and the dates you were there:

1. __________________________________ Dates: ____
2. __________________________________ Dates: ____
3. __________________________________ Dates: ____
4. __________________________________ Dates: ____
5. __________________________________ Dates: ____

COVID Vaccine

Date 1st dose:_____________________ Product Name/Manufacturer:__________________________

Date 2nd dose:____________________ Product Name/Manufacturer:__________________________

Signature: ____Date__________

Student Name________________________________ M00#_________________________________

Monroe Community College
STATE UNIVERSITY OF NEW YORK

Section 1
Radiology Technician Health History Form

Student to Complete

Demographics

Today's Date: Date of Birth:

Student Address:

Cell Phone #: Home Phone #:

Emergency Contact: Phone:

Primary Doctor Name: Primary Doctor Phone:

Health Insurance Carrier: ID Number:

Allergies

Please list all allergies (such as to drugs, bees, latex, etc.)

Substance: Reaction: Treatment:

Substance: Reaction: Treatment:

Substance: Reaction: Treatment:

Substance: Reaction: Treatment:

Medicines

Please list all you use, including over the counter medicines

Medicine: Dose: Times/Day: Used For:

Medicine: Dose: Times/Day: Used For:

Medicine: Dose: Times/Day: Used For:

Medicine: Dose: Times/Day: Used For:

Confidential Health History

Mark each that apply, add details or more information below.

ADD ADHD Anxiety or Panic Attacks Asthma Back Problems

Colitis Concussions/Head Injuries Depression Eating Disorder

Type 1 Diabetes Type2 Diabetes Hearing Impaired/Deaf Heart Problems

High Blood Pressure History of Fainting Migraines Neurological Issue

Severe Menstrual Cramps Thyroid Issues Tuberculosis Uncorrected Vision Problem

Seizures: Petit Focal Grand Last Seizure:____________________

More Information:

Hospitalizations:

Surgeries:

I attest to the truthfulness of the above statements and that I am free from habituation or addiction to depressants, stimulants, narcotics and other behavior altering substances.

Student Signature:____ Date:__________________

Student Name________________________________ M00#______________________

Section 2
Radiology Technician Technical Standards

Student to Complete

Technical Standards/Physical Demands Required

1. Able to reach, move and adjust x-ray equipment located to a height of 72 to 80 inches from the floor (may use a 6-inch footstool). Yes No

2. Remove, lift and carry 5 cassettes, weight about 25 pounds. Yes No

3. Move patient in a wheelchair or stretcher from a waiting area into the x-ray room. Yes No

4. Assist a patient out of a wheelchair onto the x-ray table. Yes No

5. Assist and physically support a patient, possible weak and unable to walk, stand, sit or lie down. Assist a patient to sit up in bed or on a stretcher. Yes No

6. Assist, as a member of a team, in moving a patient from a stretcher or bed onto the x-tray table.

   Yes No

7. Give clear, verbal commands to the patient while positioning a patient for an x-ray procedure, and at a distance of 6-10 feet from the x-ray table while located in a lead protected exposure control booth.
   Yes No

8. Have hearing corrected to be able to hear a patient at a distance of 6-10 feet, while located in a sound absorbing, lead protected exposure control booth. Yes No

9. Have sight corrected to read and adjust x-ray control panel (size of digital display of a microwave).
   Yes No

10. Are you using illegal drugs? Yes No

11. Maintain an alert level of consciousness and orientation to time, place and person at all times.

    Yes No

    If you answered no, please explain.

    ____
    ____
    ____
    ____

Student Must Sign:

I attest to the truthfulness of the information above, and that I am free from habituation or addiction to depressants, stimulants, narcotics and other behavior alerting substances.

Signature:______________________________________ Date: ________________

Student Name________________________________ M00#________________________________

Health Services
MONROE COMMUNITY COLLEGE

Section 3
Vaccine Requirements

Meningitis

You must choose one option.

1. Provide Proof of a Meningitis ACWY Vaccine received in the past 5 years that is in Section 4, #5. (If you are not sure if you received this vaccine, or if it was over 5 years ago, decline below for now)

OR

2. Decline the vaccine by signing below attesting that: I have reviewed the information regarding meningococcal disease available at health.ny.gov/publications/2168, in print in the health office, or at Health Services webpage under Immunizations. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal disease. I understand this does not prevent me from receiving the vaccine in the future, from my private health care provider, local health department or the Monroe County Health Department's Immunization Clinic at 111 Westfall Rd, Rochester, NY 14620, (585) 753-5150.

Student Signature (parent if under 18):____

Date:____________________

Hepatitis B

You must choose one option.

1. Provide proof of the Hepatitis B vaccine series that is in Section 4, #4 or a positive immune titer

OR

2. Decline the Vaccine by signing below: (*you are not required to receive the vaccine)*

I understand that due to my possible exposure to blood or body fluids in my training, I may be at risk of acquiring Hepatitis B virus infection, a serious liver disease. I decline the vaccine at this time. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I wish to be vaccinated with the Hepatitis B vaccine, I can receive this vaccine from my physician or from the health care agency that employs me.

Student Signature (parent if under 18):____

Date:____________________

Student Name________________________________ M00#_________________________________

Health Services
MONROE COMMUNITY COLLEGE

Section 4
Tuberculosis & Required Immunizations

Provider to complete this section.

Tuberculosis

Student must show proof of one of the following:

☐ Tuberculin Skin Test within past year: Date placed_____________ Date read_______________
Result in mm:_____________ Result is:____Positive_____Negative

☐ IGRA Blood Test within past year: Date__________ Result is:____Positive_____Negative

☐ For those with a new positive TB Test or Known Past Positive:

- Student must show proof of Negative Chest X-Ray completed at any time after the + test.
  Date of Positive Test:____________Date of Chest X-Ray:_____________
  Chest x-ray result:_____Normal____Abnormal
  Treatment or Referral: ____
- Check Off Any Symptoms Shown in Past Year (Check All That Apply)
  ____None ____Night Sweats ____Unexplained Weight Loss ____Cough for 3 Weeks
  ____Unexplained Fever ____Bloody Sputum ____Unexplained Fatigue

Signature of Health Care Provider:____Date:__________________

Immunization Requirements for All Students

1. Proof of Immunity to Measles, Mumps and Rubella by One of The Following:

   Two MMR Vaccines #1____________________#2______________________OR

   Positive IgG Immune Titers: (Attach Test Results or Enter Dates Below):

   Rubeola titer:________________Rubella titer:____________________Mumps titer:__________________

2. Proof of Immunity to Varicella by One of The Following:
   - Two Varicella (Chicken Pox) Vaccines: #1: _________________#2: ________________
   - Date of Positive Varicella titer:________________(or you may attach lab results)
   - Date of Varicella Disease Diagnosed by Provider:_____________
   - Date of Herpes Zoster (Shingles) Diagnosed by Provider:_____________

3. Tetanus Booster in Past 10 Years**:** Date:_____________Circle One: Tdap Or Td

4. Proof of Immunity to Hepatitis by one of the following (or student may sign the Declination in Section 3)
   - Date of Doses: #1:______________#2:_______________#3:_______________
   - Date of positive Hepatitis B Surface Antibody Titer:_________________(or attach lab results)

If student is in process in the series, student should sign the declination and send in vaccine dates as received.

5. Meningitis ACWY Vaccine within 5 Years (or student may sign the Declination in Section 3)
   - Date:____________________

6. Date of Influenza Vaccine for Current Season:____________________

Radiology Technician Physical Exam

Student Name:______________________________________DOB:______________M00#: ___________________

To Be Completed by Health Care Provider.

Physician or health care provider, carefully read the following statement, and check the appropriate boxes.

1. Are there musculoskeletal restrictions related to mobility, range of motion, lifting, or manual dexterity?
   ___Yes ___No
   If yes, please explain: ____
2. Are there uncorrected hearing restrictions which would impair the student from hearing audible alarms or engaging in telephone or oral communication with patients? ____Yes ____No
   If yes, please explain:____
3. Are there uncorrected sight restrictions which would impair the student from accurately reading gauges and calibrated equipment? ___Yes___No
   If yes, please explain: ____

I performed the above medical evaluation and found to the best of my knowledge, him/her to be free from physical or mental impairments, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior-altering substances which might interfere with the performance of his/her duties or would pose a potential risk to patients or personnel.____Yes____No

If **NO** is checked**,** please identify those problems which might interfere with the performance of his/her duties or would pose a potential risk to patients or personnel. ____
____
____

Allergies:____

Medications & Supplements: None or____
____

Height:____________Weight:____________Blood Pressure: _____/_____Pulse:_______

Area Examined	Check Below if Normal	Describe Abnormal Findings
• Hand/Skin	________	________
• Head/Eyes	________	________
• Ears/Nose/Throat/Mouth	________	________
• Neck/Nodes	________	________
• Chest/Lungs	________	________
• Cardiovascular	________	________
○ Carotid Arteries	________	________
○ Neck Veins	________	________
○ Apical Pulse	________	________
○ Heart Sounds	________	________
• Abdomen	________	________
• Musculoskeletal/Extremity	________	________
• Musculoskeletal/Spine	________	________
• Nervous System	________	________
• Genitourinary	________	________

Date of Exam (Must Be Within One Year):______________________

Health Care Provider's Signature or Stamp (With Title): ____

Print Health Care Provider's Last Name: ____

HCP's Address: ____

Office Phone #:______________________________Office Fax #:_______________________________________