Student Name_____ M00#_____

Monroe Community College
STATE UNIVERSITY OF NEW YORK

Health Services Department
Surgical Technology 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.

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
Surgical Technology 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#_____

Monroe Community College
STATE UNIVERSITY OF NEW YORK

Section 2
Surgical Technology Technical Standards

Student to Complete

The Surgical Technology Program Criteria for admittance to the clinical site require the student to be able to function cognitively and perform multiple complex and/or fine activities involving gross motor activity of the upper and lower extremities. The student anticipates to the best of his/her knowledge to possess and be able to:

1. I attest that I have adequate visual acuity (with or without corrective lenses.) ☐ Yes ☐ No
2. I attest that I have sufficient physical ability and manual dexterity to meet program requirements including: the ability to stand, walk, kneel, lift, bend, push, carry, hold, grasp without assistance and without assistive devices for long periods of time with minimal/no breaks. ☐ Yes ☐ No
3. I attest that I have sufficient hearing (with or without hearing aids). ☐ Yes ☐ No
4. I attest that I have positive interpersonal skills in patient, staff, and faculty interactions. ☐ Yes ☐ No
5. I possess short- and long-term memory sufficient to perform tasks such as, but not limited to, mentally tracking surgical supplies and performing anticipation skills intraoperatively. ☐ Yes ☐ No
6. I attest that I can lift and carry a minimum of 35 pounds across a room. ☐ Yes ☐ No
7. I attest that I have communication skills necessary to meet objectives of the program and can communicate and understand fluent English both verbally and in writing. ☐ Yes ☐ No
8. I attest that I am emotionally and physically stable to function in a high stress environment. ☐ Yes ☐ No
9. I attest that I can demonstrate the use of positive coping skills under stress. ☐ Yes ☐ No
10. I attest that I can demonstrate calm and effective responses, especially in emergency situations. ☐ Yes ☐ No
11. I attest that I can make appropriate judgements and decisions. ☐ Yes ☐ No
12. I attest that I can refrain from nourishment or rest room breaks for up to 8 hours. ☐ Yes ☐ No
13. Assemble equipment large and small. ☐ Yes ☐ No
14. Move, manipulate O.R. equipment such as O.R. tables, beds, stretchers and complete case carts. ☐ Yes ☐ No
15. Drape equipment and the surgical patient without contamination of surgical field with speed, accuracy and efficiency. ☐ Yes ☐ No
16. Be able to maintain sterility of surgical field using time, efficiency and accuracy. ☐ Yes ☐ No
17. Assist with transfer and transport of patients. ☐ Yes ☐ No

Student Name_____ M00#_____

18. Assist with/and or lift, move, position, and manipulate, with or without assistive devices, the patient who is unconscious. ☐ Yes ☐ No

19. Assist with surgical prep of patients which involves elevation of extremities while the RN circulator, assist or surgeon prepares the limb. ☐ Yes ☐ No

20. Manipulate instruments, supplies, and equipment with speed, dexterity, and good hand-eye coordination.
☐ Yes ☐ No

21. Draw up medications/solutions in a syringe in a sterile manner from the sterile field. ☐ Yes ☐ No

22. Pass instruments quickly and efficiently. ☐ Yes ☐ No

23. Demonstrate manual dexterity. ☐ Yes ☐ No

24. Demonstrate sufficient visual and tactile ability to load a fine (10-0) suture onto needles and needle holders with/without corrective lenses and while wearing safety glasses properly, quickly and safely.
☐ Yes ☐ No

25. Provide a safe environment for sharps on the sterile field in the operating room. ☐ Yes ☐ No

26. Hear and understand muffled communications without visualization of the communicator's mouth/lips and within 20 feet. ☐ Yes ☐ No

27. Hear activation/warning signals on equipment. ☐ Yes ☐ No

28. Be able to retain information regarding the steps of surgical procedures so as to anticipate the needs of the surgeons. ☐ Yes ☐ No

29. Demonstrate sufficient peripheral vision to anticipate and function while in the sterile surgical environment. ☐ Yes ☐ No

30. Detect odors sufficient to maintain environmental safety and patient needs. ☐ Yes ☐ No

If you have answered "no", please explain:

_____

_____

_____

_____

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

Student 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:_____

Health Services
MONROE COMMUNITY COLLEGE

Section 5 Surgical Technology 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:_____

Uncorrected Vision: R_____/_____L _____/_____ Corrected Vision: R _____/_____L _____/_____

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

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	_____	_____

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

Print Health Care Provider's Last Name: _____

HCP's Address: _____

Office Phone #:_____Office Fax #:_____

Return to: Monroe Community College - Health Services Department, 1000 East Henrietta Road, Rochester, NY 14623
(585) 292-2018 Fax (585) 292-3856