



# 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.***

- 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 1<sup>st</sup> (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 also 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. **Results must include placement date/time, reading date/time, and a mm induration reading.** Depending on the clinical sites that you attend, you may be required to submit a Two-Step Test *or* a Second PPD.
- Tetanus Shot (Tdap):** NCCC and clinical affiliates are requiring proof of a Tdap shot within the last ten years.
- Varicella/Zoster & Hepatitis B Information Sheets:** copies below. Complete the enclosed documents. As noted on the Varicella/Zoster document, in addition to the form, you are required to submit either proof of Varicella vaccination *or* a positive Varicella titer.
- 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.
  
- **COVID-19 Vaccination:** Proof of vaccination is currently no longer a requirement to attend courses within the SUNY system, or to attend clinical rotations at any Radiologic Technology clinical locations. However, while a change to this requirement is not anticipated, this is subject to change based on clinical site or SUNY requirements due to disease prevalence.

**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

## 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

Name:

Last Name

First Name

M.I.

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

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

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

If checked any of the above, 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: \_\_\_\_\_

\_\_\_\_\_



*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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height: _____	Weight: _____	Blood Pressure: _____
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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:**

<b>Lab tests at Physician's discretion:</b>	<b>Hemoglobin or Hematocrit:</b>	<b>Urinalysis:</b>	<b>Other:</b>
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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**  
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**

## CDC Guidelines Nosocomial Infections

### 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.

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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**

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Print Name

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Signature

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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 carriers of 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 carriers 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 carriers 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.