

BROWARD COLLEGE RADIOGRAPHY PROGRAM ADMISSION MEDICAL HISTORY & PHYSICAL EXAMINATION

In order to participate in the clinical portion of any health science program, the student must complete a Medical History and Physical Examination Form. Admission into the Radiography Program is provisionally based upon acceptance of the approved health evaluation record.

Failure to submit the original form - complete with documentation - may prevent the student from progressing to the clinical portion of the program. Valid verification of immunizations is required for eligibility to attend clinicals at the health care agencies.

Students are responsible for the cost of the physical examination and any related expenses.

Section 1: Student Self-Report of Medical History

This section about past and current health status should be completed by the student **prior** to having the physical examination.

Section 2: Medical History and Physical Examination

The Health Care Examiner will review any documentation the student provides.

Immunization Verification

- I. A PPD and/or CXR required annually, within the past 12 months. The PPD result must be documented in millimeters of induration. If a PPD is positive, a chest x ray is required every year. QuantiFERON TB Gold Test is not accepted.
- II. A Tdap (Tetanus, Diphtheria, and Pertussis) vaccine is required within 10 years of the date of the examination.
- III. A seasonal flu vaccine is required with documentation during flu season.
- IV. Measles, Mumps, Rubella, Varicella, titers must be completed to verify immunity. Titers must be completed within 10 years of the date of the examination. All negative results necessitate a vaccination. If the Measles, Mumps, Rubella or Varicella titer is negative, two post-titer MMR or Varicella boosters are required. A student stating that they have had the disease is NOT acceptable documentation
- V. Hepatitis B titer must be completed within the past ten years. If negative, the Hepatitis series must be completed (0, 1 month, 2 months after the second dose – 6 months after if using the combined Hepatitis A & B vaccine) OR the student can decline.
- VI. Results of all laboratory blood tests and diagnostics are required.
- VII. Examiner must initial after completing each section.

Health Care Examiner's Statement

This section is to be completed by a Licensed Professional Health Care Examiner (MD, DO, ARNP or PA **only**). All sections must be completed with a signature provided.

The following sections must be reviewed and signed by the student:

Section 3: Release of Information

Section 4: Verification of Compliance with Technical Performance Standards

Section 5: Permission to Render Medical Treatment

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Section 1: Student Self Report of Medical History – Please Print

Last Name	First Name	Student ID	
Address	City	State	Zip
Home Phone	Work Phone	Cell	
Emergency Contact Name	Relationship	Contact at:	
BC Email Address			

Review of Systems / Medical History — please check all that apply

Abnormal Bleeding	<input type="checkbox"/>	Hernia	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Intestinal / Stomach	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Low Back Condition / Scoliosis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Mental Disorder	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Neck Condition	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	Neurological Disorder	<input type="checkbox"/>
Concussion / Head Injury	<input type="checkbox"/>	Orthopedic Disorder	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Prior Surgery	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
Ear Problem / Hard of Hearing	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	Sickle Cell Trait	<input type="checkbox"/>
Eye Problem / Vision Loss	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>
Fracture of	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>
Gallbladder Disease	<input type="checkbox"/>	Splenectomy	<input type="checkbox"/>
Headaches / Migraines	<input type="checkbox"/>	Sprain of	<input type="checkbox"/>
Heart Murmur or Arrhythmia	<input type="checkbox"/>	Syncope / Fainting	<input type="checkbox"/>
Heart Problem (other)	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>

Provide information regarding any of the boxes checked above. Explain medical/psychological occurrence and current status.

Please indicate any health concerns, if any, that you presently have:

Allergies: _____None _____Latex _____Penicillin/Ampicillin _____Other

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Last Name	First Name	Date
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Section 2: Medical History & Physical Examination

Examiner: Please examine this student as you would for a routine check-up. This student will be working closely with clients in various health care settings. Please indicate/comment on any abnormal findings; using additional sheets if necessary or providing further documentation.

HEIGHT: _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____

SYSTEM	NORMAL	FINDING	COMMENTS/PREVIOUS CONDITIONS/SURGERY
Cardiovascular			
Endocrine/Metabolic			
Eyes/Ears/Nose /Throat			
Gastrointestinal			
Genitourinary			
Integumentary			
Musculoskeletal			
Neurological			
Respiratory			

Examiner: Summarize diagnosis, treatment and prognosis or provide any official documentation as it relates to any written response.

Is the student currently taking any medications? YES NO
If yes, please list:

Is the student restricted from participating in unlimited physical activities in the clinical area? YES NO
If yes, please specify limitation:

Does the student require any follow-up health supervision? YES NO
If yes, please specify:

Within the last 5 years, has the student been treated for substance related (drug/alcohol) disorder? YES NO
If yes, please specify:

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Last Name	First Name	Date
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Student Name:		
Mantoux PPD – Tuberculin Test and/or CXR required annually – within past 12 months		
PPD Test Date	Attach supporting documentation	
Date & Time Administered	Administered by	
Manufacture of PPD	Expiration Date	Lot Number
Date Read	Read By	
Results in Millimeters of Induration		
If results are positive or restricted from a PPD due to the BCG vaccine, a chest X-ray is required		
Chest X-ray Date	Attach Results of Chest X-ray	Examiner's Initials
Tdap (Tetanus, Diphtheria, Pertussis) – within 10 years		
Date Vaccination Provided	Attach supporting documentation	Examiner's Initials
Flu Vaccine - seasonally between September 15 & March 31		
Date of Vaccine	Attach supporting documentation	
Lot Number	Examiner's Initials	
MMR - Rubeola(Measles), Mumps(Parotitis), Rubella(German Measles) within 10 years		
Date Titer Completed	Attach supporting documentation	Examiner's Initials and date
#1 Date Booster completed for Negative Titer	Examiner's Initials and date	
#2 Date Booster completed for Negative Titer	Examiner's Initials and date	
Varicella – Chickenpox – within 10 years		
Date Titer Completed	Attach supporting documentation	Examiner's Initials and date
#1 Date Booster completed for Negative Titer	Examiner's Initials and date	
#2 Date Booster completed for Negative Titer	Examiner's Initials and date	
Hepatitis B Titer - within 10 years		
Date Titer completed	Results	Examiner's Initials
Hepatitis Series – within 20 years		
#1 Date Booster completed	Examiner's Initials and date	
#2 Date Booster completed	Examiner's Initials and date	
#3 Date Booster completed	Examiner's Initials and date	
I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline Hepatitis B vaccination at this time. I understand that by refusing to take this vaccination, I continue to be at risk of acquiring Hepatitis B.		
Student Signature required:		Date:
Health Care Examiner's Statement		
I have verified that the individual I have examined is the individual on this form and that the above tests/vaccinations were performed in this office/laboratory or I have reviewed any documentation relative to the student's immunization record.		
Examiner's Name: (Please Print) _____		
Signature of Health Care Examiner: _____		
License # _____	Phone: _____	Date: _____

Last Name	First Name	Date
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Section 3: Release of Information

In conformance with 20 U.S.C. 123g (Family Education Rights and Privacy Act) and Section 228.093, Florida Statutes, I authorize Broward College and its agents to release and disclose the information contained in this form, including my immunization record, upon request, to a clinical affiliation site

____ I herein **give** permission to duplicate the requested information and release it to the clinical site.

____ I **do not** give permission to duplicate the requested information and release it to the clinical site.

Student Signature: _____ Date: _____

Section 4: Verification of Compliance with Technical Performance Standards

The Health Science Education has outlined specific Technical Performance Standards that serve to inform students of skills and/or physical/psychological demands necessary for program completion and workplace responsibilities.

After review of the Technical Performance Standards for my program of study (attached):

____ I **have determined that I will be able to perform the standards or essential skills listed.**

____ I **have determined that I will be able to perform the standards or essential skills listed but will require reasonable accommodation.** I have registered with Disability Services and will arrange to meet with the Associate Dean to determine the accommodation necessary.

Student Signature: _____ Date: _____

Section 5: Permission to Render Medical Treatment

In case of serious illness or accident, I give Broward College or its representative(s) permission to secure medical and/or surgical care to include transportation to a physician or hospital of their choice, examination, medication, and surgery that is considered necessary for my good health. I understand that I am responsible for any cost incurred if not covered by the Health Care Agency Affiliation Contract or by the Health Science accident insurance.

Student Signature: _____ Date: _____

Last Name	First Name	Date
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**Technical Performance Standards
Radiography Program**

The technical performance standards of the Health Science programs outline the expectations and abilities considered essential for student success relative to achieving the level of competency required for graduation. Potential students should carefully review all of the standards as detailed below.

Data Collection Standards

- Tactile ability sufficient for collection and assessment of data such as pulse and temperature.
- Ability to adjust settings on equipment as needed.
- Auditory ability sufficient to monitor and assess health care needs including but not limited to hearing monitor alarms, emergency signals, auscultatory sounds, and verbal communication as when a patient/client calls for assistance.
- Visual ability sufficient for assessing and observing the patient/client and environment including near and far acuity, depth perception, visual fields, and color vision. Be able to distinguish between slightly different shades of gray.

Communication Standards

- Possess sufficient communication skills to interact effectively with others verbally, non-verbally and in written form demonstrating sensitivity to individual and cultural differences.
- Ability to express self verbally in a language that will be understood by a majority of patients/clients.
- Possess ability to recognize, interpret and respond to non-verbal cues from patients and clients.

Sensorimotor Standards

- Gross and fine motor abilities sufficient to provide safe and effective care including the ability to assist with positioning of patients.
- Standing and walking for extended periods of time and physical abilities sufficient to move from room to room, to maneuver in patient rooms and other small areas
- The motor skills of stooping, kneeling, crouching, crawling, reaching, and handling such as required to assist patient/client during a radiation therapy procedure
- Ability to perform medium work (defined as lifting 60 pound maximum with frequent lifting or carrying of objects weighing up to 30 pounds) such as required to manually move medical equipment
- Ability to walk with good balance, resist challenge while walking and support a patient/client who may have poor balance/weakened musculature during gait, ability to negotiate environmental barriers safely with patient/client
- Fine motor coordination (manual dexterity) sufficient to manipulate and use medical equipment and computers for treatment planning
- Independent mobility including transportation to/from campus and clinical courses
- Stamina to participate in physical activity over prolonged periods of time while positioning a patient/ client and providing physical assistance to patients/clients.

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Intellectual and Conceptual Standards

- Ability to assimilate, within a reasonable amount of time, large amounts of complex, technical and detailed information from a variety of sources
- Ability to identify cause-effect relationship in order to make judgments and set priorities in clinical situations
- Recognize physiological changes in patient/client status and act appropriately
- Ability to function during stressful situations
- Ability to prioritize multiple tasks, integrate information and make decisions promptly

Behavioral and Social Standards

- Possess sufficient interpersonal skills to establish meaningful and effective rapport with patients/clients, families, and colleagues from a variety of different social, emotional, economic, cultural, ethnic, religious and intellectual backgrounds as well as within all age groups
- Ability to cope with heavy workload schedule and patient demands
- Function effectively during periods of high stress
- Display adaptability
- Accept responsibility for own behavior
- Engage in self-assessment activities which includes identification of learning needs

Ethical Standards

- Exhibit a respect for truth and a commitment to honesty in all didactic and clinical pursuits adhere to ethical and legal guidelines established by applicable national organizations and governmental agencies
- Abide by all institutional regulations.
- Appreciate and respect patient/family confidentiality
- Information detailed on the Medical History and Physical Examination form is legally privileged and confidential. It is intended for use by the Health Science program unless written consent has been provided for release to other parties.