HEALTH PROFESSIONS HEALTH REQUIREMENTS

Checklist

- ★ **Important:** HEALTH PROFESSIONS (HLTP) health requirements differ from the college health requirements. HLTP students must submit this completed Physical Form.
- ★ **When: HLTP students must have submitted a completed checklist and all required documents in person to MVCC's Health Center. Please provide the Health Center with the original and a COPY of your records. No documents will be accepted without presenting a copy. The due date for submission is no later than August 1ST.**
- ★ **Where to submit: UTICA CAMPUS, Health Center, located in ACC104.**
- ★ ***Important note**: Students without completed health documents are **not** allowed to attend clinical and will be placed on clinical probation which may lead to dismissal from the program.*

Students: Please take this HLTP Health Physical Form to your Health Care Provider and CHECK to assure your submission is complete as partial submissions will not be accepted.

☐ **Physical obtained after July 15 of the year that the student is attending courses.**	All Physical documentation is due August 1, prior to the start of student's radiologic technology course. A complete physical is required **every year.**
☐ **Documentation of Tuberculin Test (also referred to as Mantoux or PPD)**	This test is required 3 months prior to a clinical placement. Results must be documented by a Healthcare provider and/or include a copy of the report.
☐ **Full sequence (2 doses) verified for: Rubella, Rubeola, Mumps & Varicella** **OR submit a copy of the titers with Lab reports** ☐ ***1) Rubella titer* Lab results must be positive*** ☐ ***2)Rubeola titer* Lab results must be positive*** ☐ ***3) Mumps titer * Lab results must be positive*** ☐ ***4) Varicella titer * Lab results must be positive***	***What if my lab results are equivocal or negative?*** *If results are **negative** booster shots are required and follow up titers must be scheduled with your healthcare provider. **Students submit positive titers one time only**
☐ **Healthcare provider documentation on the form of Tetanus toxoid**	Immunization within 10 years.
☐ **Students should expect to submit proof of flu vaccine when it becomes available each year**	Flu immunization may be required pending clinical site requirements determined each fall.
☐ **Documentation on the form of Hepatitis B immunization sequence**	Recommended. Students may opt to sign the waiver on page 2.
☐ **Documentation on the form of Meningitis immunization**	Recommended. Students may opt to sign the waiver on page 2.
☐ **Student must provide a COPY of an American Heart Association CPR BLS for the Healthcare Provider**	It must be an **American Heart Association** Healthcare Provider CPR certification. This course is valid for 2 years and cannot expire before all your core courses are complete.

STUDENTS ARE REQUIRED TO MAKE COPIES OF ALL SUBMITTED HEALTH DOCUMENTS FOR THEIR RECORDS.
A copy machine is available in the MVCC Library to copy any documents

For more information on the above immunizations please visit http://www.immunize.org/vis/

Health Profession (HLTP) Student Physical Health Form

- ***Required*: Tuberculin Test** *(Mantoux/PPD) required*

  Admin Date ____/____/____ Reading Date ____/____/____ Result _____ **(Must be repeated yearly)**

  If test is positive: Date of CXR ____/____/____ Result _____

- ***Required*: MMR Sequence** Dose #1 ____/____/____ Dose #2 ____/____/____

  Or Titers:

*** *Students must submit a copy of the lab report.* Titer results are required to be positive. Please note that if titer results are negative or equivocal, appropriate booster shots must be administered and a follow up titer appointment scheduled**

1) *Rubella Results _____ Date of booster shot: ____/____/____
2) *Rubeola Results _____ Date of booster shot: ____/____/____
3) *Mumps Results _____ Date of booster shot: ____/____/____

- ***Required*: Varicella Sequence** Dose #1 ____/____/____ Dose #2 ____/____/____

  Or Titer* Date ____/____/____ Result _____

- ***Required*: Tetanus toxoid within 10 years** Date____/____/____

- ***Required*: Current fall Influenza Vaccine** Date____/____/____
  (Flu vaccines will be required when available)

- ***Recommended*: Hepatitis B sequence, student waiver listed below.**

  Requirement: 3 doses of vaccine or positive Hepatitis surface antigen antibody immunization

  Shots Dose #1____/____/____ Dose #2____/____/____ Dose #3____/____/____

  Or Titer* Date ____/____/____ Result _____

Waiver: I have read, or have had it explained to me, the information regarding Hepatitis B disease.
I understand the risks of not receiving the vaccine. I have decided that I will not obtain testing and/or immunization.

X_____ _____ _____ **X**_____
Student's signature Age Date Parent/guardian signature (under 18 years old)

- **MENINGITIS RESPONSE**
  Check one box: I have (for students under the age of 18: My child has):

☐ had a meningococcal immunization within the past 5 years. The vaccine record is attached.

☐ I plan to obtain immunization against meningococcal disease within 30 days from my private health care provider or other public or private health care provider.

☐ I have either read, received, or acknowledge the website link below containing the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child, if under 18) will NOT obtain immunization against the meningococcal disease at this time.
http://www.mvcc.edu/health-center/meningitis

X_____ _____ _____ **X**_____
Student's signature Age Date Parent/guardian signature (under 18 years old)

MVCC Health Information Technology Program Essential Functions

The essential skills and relevant activities are listed for your review so that potential students and healthcare providers can decide whether or not they may be able to complete the requirements for the radiology program. MVCC complies with the Americans with Disabilities Act of 1990. The college will endeavor to make reasonable accommodations for an applicant with a disability, who is otherwise qualified. Applicants who are unsure if they can meet these essential skills or know they will need help in meeting them should contact the College's Disability Services Office (315) 792-5644 to discuss accommodations and/or auxiliary aids.

A student in the associate degree radiology program must have the abilities and skills necessary for use of the nursing process. The following is a representative list of the essential skills, with or without accommodation, expected of students enrolled in the Health Information Technology program.

1. Demonstrate discretion and assurance of patient right to privacy and confidentiality at all times.
2. Demonstrate assertiveness while maintaining professionalism when encountering tense situations.
3. Demonstrate the ability to diffuse emotions while solving problems.
4. Demonstrate the ability to be detailed oriented.
5. Demonstrate the ability to stay focused in stressful situations.
6. Demonstrate basic understanding of medical terminology, human anatomy and physiology, pathophysiology, and pharmacology.
7. Demonstrate logic and the ability to analyze information.
8. Demonstrate the ability to adapt to new technologies and software applications.
9. Demonstrate the ability to communicate effectively and efficiently in English, both written and verbally.
10. Demonstrate respect of self and others.

If there are any reasons why you may not be able to perform these functions with or without reasonable accommodations, you must notify the Program Coordinator, Clinical Coordinator, or Clinical Instructor immediately.

This student has had a complete physical, can complete the Essential Functions, and is in satisfactory physical condition to care for infant, child, and adult patients in an actual hospital/clinical setting.

Health Care Provider Signature: _____ Date: ____/____/____

Health Care Provider Name and Title (Print): _____

Address_____ Phone (_____) _____

CPR CERTIFICATION FORM

Complete one option below:

☐ Print e-card from https://ecards.heart.org/student/myecards (if applicable)

☐ Instructor Verification

I affirm that _____has completed the
(Student first/last name)
American Heart Association Basic Life Support for Healthcare Professionals at the below authorized Training Center.

Training Center: _____

_____

Instructor Name: _____

Instructor Phone #: _____

Date Granted: _____

Certificate ID#: _____

Instructor Signature _____

☐ Copy of Card

MVCC offers a CPR BLS for Healthcare Professionals Certification from the American Heart Association
Please visit https://www.mvcc.edu/CCED or call (315) 792-5300 for more information

STUDENT EMERGENCY CONTACT FORM

Name _____

M# _____ Date of Birth _____

Personal Contact Info:

Home Address_____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Emergency Contact Info:

(1) Name_____Relationship_____

Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer _____

(2) Name_____Relationship_____

Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer _____

Medical Contact Info:

Doctor Name. _____ Phone # _____

Dentist Name _____ Phone # _____

☐ I have voluntarily provided the above contact information and authorize MVCC and its representatives to contact any of the above on my behalf in the event of an emergency.

☐ I choose not to furnish any emergency contact information to MVCC at this time.

Student Signature _____ Date _____