Radiologic Technologies Student Health Forms

Mandatory for Participation in Clinical Assignments

Return completed forms in enclosed envelope to:

Concordia College New York
Attn: Student Health Center
171 White Plains Rd
Bronxville, NY 10708

Or scan forms and email to:

Susan.Crane@concordia-ny.edu

IMPORTANT

NO STUDENT WILL BE PERMITTED TO ATTEND CLASS OR CLINICAL ASSIGNMENTS UNTIL ALL FORMS ARE COMPLETED AND RETURNED IN THEIR ENTIRETY AND PROOF OF HEALTH INSURANCE COVERAGE IS PROVIDED

YOU MUST EITHER WAIVE OR ENROLL IN COLLEGE-OFFERED HEALTH INSURANCE ONLINE; INSTRUCTIONS INSIDE

AFFILIATE REQUESTS MAY REQUIRE YOU TO PROVIDE INFORMATION NOT INCLUDED IN THIS PACKET; YOUR PROMPT COOPERATION WILL HELP US CLEAR YOU FOR CLINICAL PRACTICE

Questions?

Contact the Student Health Services Office
Susan.Crane@concordia-ny.edu
914.337.9300 x2243

Revised: NOVEMBER 2019

Missing information will make this form invalid. Provider's signature, stamp, and license number must be present

CONCORDIA COLLEGE NEW YORK

Cohort:_____ **email:_____**

SEC I-A: Personal Health History (To be completed by Student)

Name: _____ (LAST NAME, FIRST IN BLOCK LETTERS)

This is a confidential record. Information you provide will be used solely as an aid to providing health care while you are a student.

Student Type: RADIOLOGICAL TECHNOLOGY: **Housing Status:** Resident____ Commuter____

Personal Information: Age: _____ Gender: Male____ Female____ Date of Birth_____

Home Address:_____ Cell #:_____
Street City State Zip

Have you attended Concordia College before? ☐Yes ☐No If yes, From _____ To_____

Person to be notified in emergency: Name:_____ Relationship:_____

Address:_____

Telephone: Home:_____ Work:_____

Personal History:

Please answer all questions. Comment on all positive answers in space allowed (see next page).

Have you had:	Yes	No		Yes	No
Scarlet Fever	☐	☐	Thyroid Disease	☐	☐
Measles	☐	☐			
German Measles	☐	☐	Surgery:		
Mumps	☐	☐	Appendectomy	☐	☐
Chicken	☐	☐	Tonsillectomy	☐	☐
Malaria	☐	☐	Hernia Repair	☐	☐
Nose/Throat Trouble	☐	☐	Other	☐	☐
Eye Trouble	☐	☐			
Recurrent Colds			Allergies to:		
Sinusitis	☐	☐	Penicillin	☐	☐
Hay Fever	☐	☐	Sulfonamides	☐	☐
Serum	☐	☐			
Joint Disease or Injury			Foods (list below)	☐	☐
"Trick" Knee, Shoulder	☐	☐	Other	☐	☐
Back Problems	☐	☐			
Diarrhea/Constipation	☐	☐	Females Only:		
Gallbladder/Gallstones	☐	☐	Irregular Periods	☐	☐
Rupture, Hernia	☐	☐	Severe Cramps	☐	☐
Jaundice (Liver Disease)	☐	☐	Excessive Flow	☐	☐
Stomach/Intestine Trouble	☐	☐	Other	☐	☐

Continued →

Name:_____

	Yes	No		Yes	No
Frequent Anxiety	☐	☐	Chronic Cough	☐	☐
Frequent Depression	☐	☐	Shortness of Breath	☐	☐
Nervousness	☐	☐	Heart Murmur	☐	☐
Head injury	☐	☐	Heart Palpitations	☐	☐
with Unconsciousness			Rheumatic Fever	☐	☐
Recurrent Headache	☐	☐	Pain/Pressure in Chest	☐	☐
Gum/Tooth Problems	☐	☐	Blood Pressure		
Acne	☐	☐	High or Low	☐	☐
Epileptic Seizures	☐	☐	Diabetes	☐	☐
Tumor, Cancer, Cyst	☐	☐	Frequent Urination	☐	☐
Dizziness, Fainting	☐	☐	Sexually Transmitted	☐	☐
Weakness/Paralysis	☐	☐	Disease (STD)		
Tuberculosis	☐	☐	Recent Weight Gain	☐	☐
Asthma	☐	☐	or Loss		

A. Has your physical activity been restricted during the past five years? ☐Yes ☐No (If yes, explain below.)
B. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?
☐Yes ☐No (If yes, give details below.)
C. Have you had any illness or injury or been hospitalized other than already noted? ☐Yes ☐No (If yes, give details below.)
D. Have you consulted or been treated by clinics, physicians, or other practitioners within the past five years?
(other than routine checkups?) ☐Yes ☐No
E. Do you smoke, dip, or chew tobacco? ☐Yes ☐No
F. Do you take any medication at present? ☐Yes ☐No (If Yes, Please list below)
G. Do you drink alcohol? ☐Yes ☐No If Yes, what type and how often?_____
H. Do you use recreational drugs? ☐Yes ☐No (If Yes, Please list below)

Comments:

_____

_____

_____

_____

Family History

Among your relatives is there any history or present illness from the following:

	Yes	No	If yes, what relative?		Yes	No	If yes, what relative?
Cancer	☐	☐	_____	Convulsions	☐	☐	_____
Diabetes	☐	☐	_____	Arthritis	☐	☐	_____
Allergy	☐	☐	_____	Stomach disease	☐	☐	_____
Tuberculosis	☐	☐	_____	Nervous difficulties	☐	☐	_____
Kidney Disease	☐	☐	_____	Any other disease	☐	☐	_____
Heart disease, high blood pressure, or stroke	☐	☐	_____				

Medical and Surgical Authorization

In case of illness and/or injury, authority and consent is given to Concordia College for examination and treatment of named student either at the Health Center, Concordia College, or by outside physicians and medical facilities as are available. Consent is further given for admission to a hospital for necessary medical or surgical treatments as ordered by a physician. It is agreed that all medical and/or hospital expenses incurred beyond those covered by any applicable student insurance policy will be paid directly and promptly by the undersigned student and parents or guardians and the College will not be held responsible.

Date _____ Student's Signature _____ Age _____

Date _____ Parent or Guardian's Signature _____

(If under age 18 and unmarried, parent or guardian must also sign.)

CONCORDIA COLLEGE NEW YORK

Sec. I-B. PHYSICAL EXAMINATION AND BLOOD TITERS (To be completed by a Health Care Provider)

Student's Name: _____ Concordia ID#: C_____

Gender (circle): M F Date of Birth: _____

Date of Exam: _____ (to be completed only by MD, DO, NP or PA)

Height: _____ Weight:_____ BMI:_____ BP:_____ Pulse:_____

Vision: R 20/ L 20/ Corrective Lenses? Y N

Current Medications: _____

Allergies to Medications: _____

Type of reaction: _____

Other Allergies: _____

Type of reaction: _____

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular System		
Abdomen (rectal if		
indicated)		
Genito-urinary		
Pelvic (if indicated)		
Musculoskeletal		
Neurological		
Psychological		
Other:		

Current & Chronic Problems

1._____ 2._____3._____

IF THE STUDENT IS UNDER CARE FOR A CHRONIC OR SERIOUS ILLNESS, PLEASE DESCRIBE BELOW AND ATTACH ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

_____

_____

RECOMMENDATIONS FOR PHYSICAL ACTIVITY: ☐ Unlimited ☐ Limited

(If limited, please specify):_____

I CERTIFY THAT THIS PATIENT IS IN GOOD PHYSICAL AND MENTAL HEALTH AND IS FREE OF COMMUNICABLE DISEASE. HE/SHE IS FULLY QUALIFIED MEDICALLY TO SERVE AS A HOSPITAL VOLUNTEER/CLINICAL TRAINEE.

_____ _____

Signature of Health Care Provider, License # and Stamp (MD, DO, NP, PA) PHONE:

MANDATORY TUBERCULIN TESTING REQUIREMENTS

No Exceptions

If you have never tested positive for TB:

Attach ONE of the following

- Lab results for a Quantiferon Gold Blood Test
- Lab results for a 2-step PPD

If you have tested positive for TB in the past:

Attach ALL of the following

- Lab results for a Quantiferon Gold Blood Test
- Chest X-ray dated within one year
- If TB treatment was administered, attach records of medication length of treatment

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COMPLETE THIS SECTION ONLY IF YOU HAVE TESTED POSTIVE FOR TB IN THE PAST

TUBERCULOSIS SCREENING QUESTIONNAIRE

Name: _____Date:_____

Positive TB skin test (PPD) Date: _____

Last Chest X-Ray Date: _____

Please indicate if you are having any of the following problems for three to four weeks or longer:

Chronic Cough (greater than 3 weeks) Yes _____ No _____

Production of Sputum Yes _____ No _____ **Blood-Streaked Sputum Yes _____ No_____**

Unexplained Weight Loss Yes _____ No_____ **Fever Yes _____ No _____**

Fatigue/Tiredness Yes _____ No _____ **Night Sweats Yes _____ No _____**

Shortness of Breath Yes _____ No _____

Did the patient ever complete treatment for latent TB? If so, when:_____

_____NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM

SIGNATURE:_____DATE:_____STAMP:_____

Health Care Provider (M.D., D.O., N.P., PA.)

MANDATORY CLINICAL REQUIREMENTS

ATTENTION

ANY VARIATION FROM THIS CHECKLIST WILL PREVENT HEALTH CLEARANCE FOR CLINICAL PRACTICE

EMR /LAB /IMMUNIZATION FORMS MUST BE ATTACHED, SIGNED AND STAMPED; HANDWRITTEN DOCUMENTATION WILL NOT BE ACCEPTED

- ☐ **MMR/measles, mumps, rubella:** document lab results for positive blood titers
- ☐ **Varicella:** document lab results for positive blood titers

NOTE: non-immunity will require additional vaccines; please check with Student Health Center

- ☐ **Hepatitis B:** document completion of 3-vaccine series
  - In order to prove immunity, you must have blood titers drawn for:
    - Hepatitis B surface ANTIBODY (anti-HBs)
    - Hepatitis B surface ANTIGEN (HBsaG)
  - **OR** sign the OSHA waiver form contained in this packet
- ☐ **Tuberculin Screening:** Quantiferon Gold blood assay is mandatory. Positive results will require a chest X-ray and the TB Questionnaire (included in this packet) to be completed and signed by your provider. Please see physical form to be completed by your primary care provider.
- ☐ **Tdap vaccine:** Must be within last 10 years. Must attach dosing documentation. Td or Dtap vaccine is NOT acceptable.
- ☐ **Meningitis vaccine:** Mandatory for living in campus housing. Students living off-campus must sign the enclosed disclosure form.

HEPATITIS B VACCINE
INFORMATION AND REFUSAL FORM

The Disease
Hepatitis B is a viral infection caused by the hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Thus, immunization against hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

The Vaccine
Recombivax HB* is a non-infectious subunit viral vaccine derived from Hepatitis B surface antigen (HBsAg) produced in yeast cells. A portion of the Hepatitis B virus gene, coding for HBsAg, is cloned into yeast, and the vaccine for hepatitis B is produced from cultures of this recombinant yeast strain. The vaccine contains no detectable yeast DNA but may contain up to 4 yeast protein. It has been extensively tested for safety in chimpanzees and for safety and efficacy in large scale clinical trials with human subjects. The vaccine against hepatitis B, prepared from recombinant yeast cultures, is free of association with human blood or blood products. A high percentage of healthy people who receive two doses of vaccine and a booster achieve high levels of surface antibody (anti-HBs) and protection against hepatitis B. People with immune-system abnormalities, such as dialysis patients, have less response to the vaccine, but over half of those receiving it do develop antibodies. Full immunization requires 3 doses of vaccine over a six month period although some people may not develop immunity even after 3 doses. There is no evidence that the vaccine has ever caused hepatitis B, non-A/non-B hepatitis, or AIDS (Acquired Immune Deficiency Syndrome). However, people who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of immunity is unknown at this time.

Possible Vaccine Side Effects
The incidence of side effects is very low. No serious side effects have been reported with the vaccine. A few people experience tenderness, redness and itching at the site of injection. Low grade fever and/or headache may occur. Rash, nausea, joint pain, diarrhea, and mild fatigue have also been reported. The possibility exists that more serious side effects may be identified with more extensive use.

IF THERE IS A POSSIBILITY OF PREGNANCY, DO NOT RECEIVE THE VACCINE.
IF YOU HAVE ANY QUESTIONS ABOUT HEPATITIS B OR THE HEPATITIS VACCINE, PLEASE ASK.

HEPATITIS B VACCINE REFUSAL:
I have read the above statements about the Hepatitis B Vaccine. I have had the opportunity to ask questions and understand the benefits and risk of vaccination. Despite the potential benefits, I prefer not to be immunized at this time. I understand I may change my decision and receive the vaccine at a later date.

_____ _____ _____
(Name – Please Print) (Signature) (Date)

C_____
Concordia ID #

_____I have received ___one (1) ___two (2), 3-vaccine series of Hepatitis B vaccine. Serology results indicate that I am *not* immune, and have declined to receive a 2nd (or 3rd) set of vaccines. I am aware of the risks and benefits of the vaccine.

CONCORDIA COLLEGE NEW YORK

Sec. II. Meningococcal Meningitis Vaccination Response Form (To be completed by Health Care Provider)

A. **Meningococcal Meningitis Vaccine (Menactra™/Menomune™):** Please consider this vaccine. Students wishing to decline this vaccine must read the information in the box below. **Signing the waiver indicates that you understand the possible risk involved in not receiving this immunization.** If you are under the age of 18, a parent or legal guardian must sign this waiver for you.

Disclosure Statement-Meningococcal Meningitis: College students, especially first-year students living in residence halls, are at a slightly increased risk for contacting meningococcal disease. The bacterial form of this disease can lead to serious complications such as swelling of the brain, coma, and even death within a short period of time. A vaccine is currently available that will decrease, but not completely eliminate, a person's risk of acquiring meningococcal meningitis. This element of uncertainty remains because there are five (5) different serotypes (A, B, C, Y, & W-135) and the current vaccine does not offer any protection from serotype B. The vaccine, Menactra™/Menomune™, probably protects for 3-5 years, and is extremely safe for use. Menactra™ vaccine is available at the Concordia Student Health Center for a cost of $125. For more specific information about meningococcal meningitis and college student risks, please visit the NYS DOH website at: www.health.state.ny.us/nysdoh/immun/meningococcal/index.htm

Mandatory - Read Carefully: As per New York State Public Health Law 2167, you must either have the vaccine or sign a waiver stating you have read about the disease and decline the vaccine.

(circle one:) Menomune / Menactra

A. Meningococcal Meningitis Vaccine (Menactra, Menomune) given within the past 10 years:

Date: ____/_____/_____ (Month Day Year) **Date: ____/_____/_____** (Month Day Year)

IT IS STRONGLY ADVISED THAT ADOLESCENTS RECEIVE A 2ND DOSE OF MENINGITIS VACCINE IF THEY HAVE RECEIVED THEIR 1ST DOSE BEFORE THE AGE OF 16.

An official stamp from a doctor's office, clinic, or health department AND an authorized signature must be provided below.

_____ _____ _____

Name/License#/Office Stamp **Signature** **Date**

OR

Read the information provided above and sign the waiver below.

_____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis disease.

Print_____Sign:_____Date:_____

Patient Information

Patient Name: _____ Birth date: _____

Student ID #:_____ Cell Phone:_____

Address:_____

Release To: (Name of Facility/Clinician/Person Receiving Information)

Name: All Clinical Sites

Release Information:

Reason: Requirement for School Health Clearance for Clinical Rotation

Please release the following:

Immunizations

Laboratory/Radiology results

Physical Exam Forms

Quantiferon Gold Blood Test

Chest X-Ray (if indicated)

PPD

Consent:

This information is intended by the above named recipient only. I am aware that the records released may contain information relating to a psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. I have a right to receive a copy of this authorization. I may revoke this authorization at any time in writing. | understand that information used or disclosed under this authorization may be subject to re disclosure by the recipient without being further protected under the HIPPA/FERPA rules.

I understand that I may be charged for copies provided.

Signature of Patient: _____Date:_____

171 WHITE PLAINS ROAD

BRONXVILLE, NY 10708

PH: 914-337-2243 FX: 914-395-4521

WAIVE OR ENROLL IN COLLEGE-OFFERED HEALTH INSURANCE

Your bill reflects a charge for the College-offered health insurance. If you are a domestic student and covered by your family's plan or another plan, you may decline the College-offered Health Insurance online at the website below.

IMPORTANT

INTERNATIONAL STUDENTS ARE REQUIRED TO ENROLL IN THE COLLEGE-OFFERED HEALTH INSURANCE

IF YOU HAVE OUT-OF-STATE MEDICAID, PLEASE CONTACT THE STUDENT HEALTH CENTER

www.gallagherstudent.com/concordiany

1. On the top right corner of the screen, click 'Student Login' and log in.
2. On the left toolbar, click 'Student Waive/Enroll'.
3. Choose to waive or enroll. Follow the instructions to complete the form.
4. Print or write down your reference number.
5. If you choose to enroll, you will receive an enrollment packet with instructions for enrolling. The charge on your bill does not indicate enrollment; please follow the instructions in your enrollment packet.

PLEASE ATTACH A COPY OF YOUR VALID HEALTH INSURANCE CARD, FRONT AND BACK