PRIDE • SERVICE • EXCELLENCE

Cumberland County College
RADIOGRAPHY PROGRAM

Medical History Information

Return to:
Radiography Department
Cumberland County College
P.O. Box 1500, College Drive
Vineland, NJ 08362-1500
www.cccnj.edu

Cumberland COUNTY COLLEGE

RADIOGRAPHY PROGRAM

Medical Information Form

Student Information

Name of Student: _____
Last First Middle

Home Address: _____

Phone No: _____

Student ID #: _____ Birthdate: _____

Person to notify in case of emergency

Name: _____ Phone #: _____
Last First

Address: _____

Relationship: _____

Personal Physician/Nurse Practitioner

Name: _____

Address: _____

Phone #: _____

Health Insurance Information

Each student is required to carry their own health insurance. **Attach copy of insurance card.**

Company Name: _____

Address: _____

Policy #: _____

REMINDER

Because the Radiography Program involves active participation in the performance of procedures within a hospital facility, you are required to show proof of cardiopulmonary resuscitation certification (CPR for Healthcare Providers).

2 A -- Medical History - ***TO BE COMPLETED BY STUDENT.***
PLEASE INDICATE YES OR NO FOR EACH QUESTION.

	Yes	No
Have you ever been diagnosed or treated for the following: If yes to any, indicate item and explain on back of page.		
1. Severe headaches, fainting spells, dizziness, Epilepsy or seizures?	( )	( )
2. Eye trouble for which you wear glasses?	( )	( )
3. Other eye trouble?	( )	( )
4. Frequent colds, sinusitis or sore throats?	( )	( )
5. Ear trouble or difficulty hearing?	( )	( )
6. Anemia or blood disease?	( )	( )
7. Persistant cough?	( )	( )
8. Coughing, spitting or vomiting of blood?	( )	( )
9. Shortness of breath ___ ? Asthma ___? Tuberculosis ___?	( )	( )
10. Pain or pressure in chest?	( )	( )
11. Pounding heart, irregular heart beat, heart disease?	( )	( )
12. High or low blood pressure ___? Stroke ___?	( )	( )
13. Indigestion, heartburn, abdominal pain or discomfort?	( )	( )
14. Hernia?	( )	( )
15. Stomach ulcers or nervous stomach?	( )	( )
16. Jaundice ___? Hepatitis ___?	( )	( )
17. Diarrhea for more than a few days?	( )	( )
18. Blood with bowel movement?	( )	( )
19. Kidney, bladder trouble (stones, bloody urine, etc.)?	( )	( )
20. Frequent or painful passage of urine?	( )	( )
21. Difficulty with feet or legs, varicose veins?	( )	( )
22. Back pain ___? Back injury ___?	( )	( )
23. Painful or trick knee or shoulder, broken bones?	( )	( )
24. Swollen or painful joints, muscles, bursitis, neuritis, arthritis, rheumatism, gout?	( )	( )
25. Persistant or recurrent skin rashes?	( )	( )
26. Periods of severe fatigue, exhaustion?	( )	( )
27. Do you consider yourself a nervous person? Had psychiatric treatment?	( )	( )
28. Diabetes?	( )	( )
29. Cancer? Explain if yes.	( )	( )
30. Mental illness?	( )	( )
31. What medications are you currently taking?		

32. Do you have any allergies? Indicate:

IMPORTANT NOTE: Hospitals can not guarantee a "latex free" environment.

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3 A -- Medical Form: ***TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER.***

1. **PLEASE ATTACH THE FOLLOWING REQUIRED LABORATORY TEST RESULTS.**
    1. Complete blood count *with* **differential**
    2. 10 panel urine drug screen (annual requirement)
    3. Tuberculin Test - if positive, chest X-ray is required only once during two year continual enrollment in program.
        a. 2 Stage Mantoux required for 1st year students
        b. Single PPD only for 2nd year students
    4. Proof of flu vaccine must be provided to the program by Nov. 1. Students not receiving the flu vaccine for any reason will be required to wear a face mask for the entire duration of their clinical assignment.

The tests listed below are only required once during your enrollment in the program.

		Date	***Vaccine***		***Titer Result***	***Date***
4.	Rubella	_____	_____	OR	_____	_____
5.	Rubeola	_____	_____	OR	_____	_____
6.	Varicella	_____	_____	OR	_____	_____
7.	Mumps	_____	_____	OR	_____	_____
8.	Hepatitis	_____	_____	OR	_____	_____

2. The following immunizations are strongly urged but not mandatory:
    1. Tetanus booster within one year of entering college. If indicated, a complete series should be done.
    2. Polio (Salk or Sabin)

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3 B -- Name of Student _____ Height: _____ Weight: _____

Blood Pressure: _____ Pulse:_____

Immunizations and Tests

Tuberculin Test Date: _____ Reaction: _____

Chest X-ray (if indicated) Date: _____ Reading: _____

Tetanus: Date: _____

Polio: Date: _____ Type: _____

Eyes:

	Uncorrected	*Corrected*
OD	20/	20/
OS	20/	20/

Audiology Screen:

Results: *(must be in numerical or graph format, WNL not acceptable)*

History: Previous operations, injuries, long illnesses: _____

_____

_____

_____

_____

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Medical Information Form

4A Clinical Evaluation (To be completed by Physician/Nurse Practitioner)

Normal	Abnormal	Check every item in appropriate column, enter "N.E." if not evaluated.	Note: Describe every abnormality in detail
		General Appearance	
		Head, Face, Neck and Scalp	
		Nose	
		Sinuses	
		Mouth and Throat	
		Ears - (general)	
		Drums - (perforation)	
		Eyes - (general)	
		Lungs and Chest	
		Heart (thrust, size, rhythm, sounds)	
		Vascular System (varicosities, etc.)	
		Abdomen and Viscera (include hernia)	
		Upper Extremities (strength, range of motion)	
		Lower Extremities (strength, range of motion)	
		Spine	
		Neurologic (equilibrium tests)	
		Psychiatric (specify)	

The Radiography Program involves both classroom activities and active participation in radiographic procedures in the clinical setting. Please specify any condition(s) that might inhibit the student's ability to meet the requirements of the program. If limitations are noted, please state your recommendations.

_____

_____

_____

_____

_____

_____ _____

Physician/Nurse Practitioner Signature Date

This report is for the use of the college and should be mailed to the Radiography Program, Cumberland County College, P.O. Box 1500, Vineland, New Jersey 08362, by the applicant's physician. The student's admission is incomplete until this report has been received. Prompt return of this form will be appreciated.