## Northwest Iowa Community College

**Health Assessment Policy**

Radiologic Technology students will be required to complete a health assessment prior to their first clinical course. This health assessment needs to be filled out by a medical professional (MD, NP, PA). This can be completed by their provider of choice and scheduled like a physical.

If a student has had surgery or other health issues a functional assessment will be required to be cleared for clinical. Also, if during simulation scenarios or in lab situations, there becomes a concern about whether the student can perform at clinical that same functional assessment will also be asked to be completed. This ensures the safety of the students but also the safety of the patients that will be cared for under their supervision.

Below is the health assessment form completed by all.

### Allied Health Programs Health Assessment

Student Name:_____ Date: _____

Program: **Radiologic Technology**

Does the student have the following:

| Vaccination | Yes/No or date administered |
|---|---|
| MMR 1 | |
| MMR 2 | |
| Tetanus/ Diphtheria/Pertussis (Tdap) | |
| HEP B #1 | |
| HEP B #2 | |
| HEP B #3 | |
| Chicken Pox #1 | |
| Chicken Pox #2 | |
| Flu- Include Entity given by. | |
| Covid (Not required by NCC) | |

If the student does not have proof of one of the above vaccines, please draw a titer and place results below:

| Titer Test | Results |
|---|---|
| Mumps Titer | |
| Measles Titer | |
| Rubella Titer | |
| HEP B Titer | |
| Chicken Pox Titer | |

Students must also have a 2-step TB test or a blood draw. Place the results below, including the date read and your initials.

| 2-step TB test | Date read and initials |
|---|---|
| TB Test #1 | |
| TB Test #2 | |
| TB Blood Draw | |

Please complete a medical history:

| Concern | Yes/No | What/Why? |
|---|---|---|
| Physical Ability/Restrictions | | |
| ENT Disorder | | |
| Dizziness, fainting, convulsions, headache, paralysis, mental disorder, or epilepsy? | | |
| Breathing problems, asthma, emphysema, tuberculosis, or chronic respiratory disorder? | | |
| Chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, other cardiovascular concerns? | | |
| Jaundice, intestinal bleeding, ulcers, hernia, hemorrhoids? | | |
| Diabetes? | | |
| Herpes, Hepatitis, AIDS? | | |
| Other major medical history | | |
| Musculoskeletal problems that would inhibit or prevent patient care, lifting, and or moving? | | |
| Medications/ Allergies | | |
| Other Comments: | | |

**Health Assessment Findings:**

I have reviewed the Iowa Core Performance Standards for Health Career Programs (last pages).

Based on my examination of the above-named student for the program listed, I find this student:

_____Able to physically perform in the program without accommodation(s)

_____Able to physically perform in the program with accommodation(s) as follow:

_____

_____

_____

_____Needs further evaluation

Student Name:_____Date:_____

Physician Signature:_____Date:_____

**FUNCTIONAL ASSESSMENT: (only completed when requested)**

Height:_____Weight:_____B/P:_____Pulse:_____Rhythm:_____

**Eyes**

Vision - Right:_____Left:_____uncorrected or corrected?____Yes___No

Tracking:

Wears glasses?____Yes___No Wears contacts?___Yes____No Color Blind?_____Yes____No

Test Performed:_____

**Ears**

Otoscopic Exam: Right:_____Left: _____

Hearing Test: Whisper Test (1-2 feet) Tuesday, armchair, baseball, and fourteen._____Yes_____No

Describe any abnormal findings:_____

_____

**Neck** within normal limit within normal limits within normal limits

L. Lat. Tilt____Yes___No Flexion___Yes___No L. Rotation___Yes___No

R. Lat. Tilt___Yes____No Extension___Yes___No R. Rotation___Yes___No

Comments:_____

_____

**Back** within normal limits within normal limits within normal limits

Flexion____Yes____No R. Lat. Tilt___Yes___No R. Rotation___Yes__No

Extension____Yes___No L. Lat. Tilt___Yes___No L. Rotation___Yes___No

Curvature____Yes___No

Lift of 50lbs from floor to waist:___Yes____No Base of Support:___Wide___Narrow

Body Mechanics: poor/fair/good Type of Lift:____Straight_____Twisted

Instruction Given:___Yes__No Comments:_____Foot Distance: __Appropriate__Too far

_____Squat:_____Deep_____Shallow

_____stoop from waist:____Able____Unable

Back Position:____Normal curves____Kyphosis

**Straight Leg Raises**: Pos. Neg. within normal limits within normal limits

R.____ _____Walks on heels_____Yes____No Gait:____Yes____No

L.____ _____ Walks on toes_____Yes____No

Comments:_____

_____

_____

**Lower Extremity**

**Knees** within normal limits Hips within normal limits Ankles within normal limits

Flexion____Yes___No Flexion___Yes___No Dorsi Flexion___Yes___No

Extension___Yes____No Extension___Yes____No Plantar Flexion____Yes___No

Int. rotation____Yes___No Eversion___Yes___No

Ext. rotation____Yes____No Inversion____Yes____No

Comments:_____

Name:_____

**Upper Extremity**

**Shoulder** within normal limits within normal limits within normal limits

Forward Flexion___Yes___No Abduction___Yes___No External Rotation___Yes___No
Backward Extension___Yes___No Adduction___Yes___No Internal Rotation___Yes___No
Shoulder Shrug___Yes___No Empty Can___Yes___No Palpation for crepitation___Yes__No
Thumb to mid lumbar region___Yes___No Drop Arm___Yes___No

Comments:_____

**Elbows** within normal limits within normal limits

Flexion___Yes___No Supination___Yes___No
Extension___Yes___No Pronation___Yes___No
Palpate epicondyles___Yes___No Forearm resisted___Yes___No
Comments:_____

_____

**Wrists** within normal limits within normal limits

Flexion___Yes___No Rotation___Yes___No Ganglion Cyst___Yes___No
Extension___Yes___No Resisted Extension___Yes___No Location/size_____
Resisted Flexion___Yes___No
Comments:_____

_____

**Hands** within normal limits within normal limits

Finger Flexion/Extension___Yes___No Phalen's Test___Yes___No Dermatitis___Yes___No
Finger Extension___Yes___No Tinel's Test___Yes___No Grafts/Scars___Yes___No
Thumb/Finger Touch___Yes___No Finkelstein Test___Yes___No Amputations___Yes___No
Pinch test___Yes___No Stereognosis___Yes___No Thenar Atrophy___Yes___No
Rotation___Yes___No Number identification in palm___Yes___No
Unusual Nail Condition___Yes___No Describe:_____

_____

Grip Strength (circle dominant hand)
Right_____ _____ _____
Left_____ _____ _____

Comments:_____

_____

Nurse's signature:_____Date:_____

**Please read and sign**

I certify that the foregoing statements are true and correct to the best of my knowledge and that I am not suffering from any illness, injury, or chronic disease except as stated. I understand that this questionnaire and nurse physical examination if applicable are provided solely in connection with requirements in connection with Northwest Iowa Community College and do not constitute a complete and comprehensive medical examination.

I understand the following:

1) all disclosures will be controlled by the occupational health nurse,
2) disclosure will be made to the student or the student's designated representative with appropriate written consent,
3) disclosure to health insurance providers is made upon appropriate written authorization, and
4) management disclosure is made on a need-to-know basis with reference only to workability status.

Date: _____ Signature: _____

Name (printed): _____