RADIOLOGIC TECHNOLOGY PROGRAM
HEALTH STATUS - PHYSICAL EXAM REPORT

Bellingham TECHNICAL COLLEGE
3028 Lindbergh Avenue, Bellingham, WA 98225-1599

Student name (print):_____ Date:_____

Students are required to have a physical examination within 6 months prior to starting clinical education. Clinical education will start on January 7. Do not complete your physical examination before July 7th.

PHYSICAL EXAMINATION

The radiologic technology curriculum requires students to engage in a variety of specific experiences fundamental to the acquisition and practice of essential radiologic technology skills and functions. Unique combinations of cognitive, affective, psychomotor, physical, and social abilities are required to perform the functions of a student radiologic technologist. These essential qualifications ensure safety for patients and are required for student participation in the radiologic technology program at Bellingham Technical College. To demonstrate that a student has met the essential qualifications students are required to complete a physical exam within 6 months of beginning clinical rotations or any time after a major change in health status, such as surgery or childbirth. Essential qualifications include (but are not be limited to) the following:

MOTOR SKILLS

- Demonstrate sufficient motor function to be able to execute movements required to provide general care and treatment to clients in all healthcare settings. Such as crouching, grasping, pulling and pushing with 25lbs of force, lifting up to 50lbs, stooping, reaching, standing for long periods, and walking several miles in an 8-hour shift.
- Perform data entry on a computer, set techniques on imaging equipment, palpate veins for IV insertion, basic life support, including CPR, and function in an emergency.

SENSORY/OBSERVATION

- Observe a client accurately, at a distance and nearby, and observe and appreciate non-verbal communications when performing assessment and interventions.
- Perceive changes in condition through physical assessment where information is derived from observation of the body surfaces and auditory information (client voice, pulse, contrast exams).

COMMUNICATION

- Communicate effectively in oral and written forms, in English with patients, faculty, and healthcare team members.
- Hear sounds at a normal range including the ability to receive dictated information.

BEHAVIORAL/EMOTIONAL HEALTH

- Emotional health required for the full utilization of intellectual abilities, the exercise of good judgment, and the prompt completion of all responsibility's when caring for the clients and families.
- Emotional stability to function effectively under stress and to adapt to an environment that may change rapidly without warning and/or in unpredictable ways.

Student has met the Essential Qualifications of Radiologic Technology students. ☐ YES ☐ NO
If not, please explain: _____

Are there any health problems or limitations that may interfere with the student's ability to complete academic or clinical assignments? ☐ YES ☐ NO If yes, please explain: _____

_____ _____

Print Name of MD, ARNP, DO or PA Signature of MD, ARNP, DO or PA

Bellingham TECHNICAL COLLEGE

RADIOLOGIC TECHNOLOGY PROGRAM
HEALTH STATUS - IMMUNIZATIONS REPORT

3028 Lindbergh Avenue, Bellingham, WA 98225-1599

STUDENT NAME_____ Date_____

Please print

REQUIRED IMMUNIZATIONS

Signatures by health care providers are required for each immunization. Please do **not** attach records to this form.

TST/TB (Tuberculin Skin Test)	TST Initial 2-step 1st Injection Date: Read Date: Results:	Provider Signature:
	TST Initial 2-step 2nd Injection Date: Read Date: Results:	Provider Signature:
	OR Negative Initial QuantiFERON/TB Gold Testing Date:	Provider Signature:
	OR Chest x-ray result: Treatment:	Provider Signature:
MMR **(Measles, Mumps & Rubella)**	1st dose date:	Provider Signature:
	2nd dose date:	Provider Signature:
	OR Titer date (verifying immunity):	Provider Signature:
Hepatitis B (Hep B)	1st dose date:	Provider Signature:
	2nd dose date:	Provider Signature:
	3rd dose date:	Provider Signature:
Tdap	(One injection since 2006) Injection date:	Provider Signature:
Influenza	Immunization date:	Provider Signature:
Varicella (Chickenpox)	1st dose date:	Provider Signature:
	2nd dose date:	Provider Signature:
	OR Titer date (verifying immunity):	Provider Signature:

CONSENT

I understand that the information provided above is to remain confidential, with the exception that clinical facilities may be informed that the required immunizations are in order or appropriate treatment is under way.

Student's signature _____ Date_____