STUDENT HEALTH SCREENING

Students in the Radiography Program at Regional West must be in good health to provide quality health care to patients in the clinical situation. To assure that students are in good physical health, a health screening and an immunization record are required. Each student will assume responsibility for managing his or her own health care, health care expenses, and for meeting health requirements.

Responsibility: Program Director, Medical Advisor, Students
Standard: Human Resources

PURPOSE

The purpose of the health screening is to ensure a safe and healthful environment for the employees, patients, other students and hospital visitors.

Each student is required to complete the Student Information Form to provide contact information and other general health information in the event of student illness or injury. Changes in the student's contact information should be immediately reported to the Program. An Update of Student Contact Information Form is attached.

Health Screening

New students will receive a Health Screening as part of the enrollment process. The Health screening will include:

1. A drug test (cannot be completed any more than 30 days prior to start of enrollment)
2. Assessment of blood pressure, weight, and height (as appropriate)
3. Blood draw for required tests (Rubeola, Rubella, Varicella, Hepatitis B antibody)
4. Latex exposure history
5. OSHA medical questionnaire for respirator usage
6. New enrollment Quantiferon Gold TB or chest x-ray
7. Hepatitis B vaccination
8. MMR, Tdap and Varicella immunizations as needed

The services described above will be provided by Regional West Medical Center or Western Pathology Consultants, Inc at no additional cost to the student. Screening beyond these services is the responsibility of the student, either by his or her personal health plan or self-pay. These services will be provided for the student only - not to any of his or her dependents.

Respirator Fit Testing Prior to the initial fit test, a student will complete a medical questionnaire for respirator usage. A student entering the Program will have a respirator fit test during the Occupational Health orientation routine. Subsequently, the student will complete the Imaging Service Department fit test routinely accomplished in March of each year.

Latex Sensitive Students Latex sensitivity/allergy is a sensitized response to latex proteins (natural latex rubber products)

Students at High Risk for Latex Reactions:

1. Students with a history of repeated surgical procedures.
2. Students with a history of asthma, drug, and food allergies.
3. Students with frequent exposure to latex via open skin or mucous membranes (For example: burns, catheterizations, gastric feeding tubes, or multiple dental procedures).
4. Students with frequent exposure to latex products.
5. Students reporting itching/watery eyes, runny nose, sneezing, itching, swelling, hives, wheezing, or collapse when exposed to latex in rubber gloves, balloons, condoms, Band-Aids, rubber toys, or other rubber items.

Students entering the Program will be surveyed for potential latex sensitivity utilizing the Occupational Health Department Screening Questionnaire/Latex Form from the Sponsoring Institution**.** The RWHS Occupational Health Nurse will assign the student a classification number to indicate the degree of risk.

Class 1: Type I – Immediate Hypersensitivity – **life threatening**

Type I Immediate Hypersensitivity is an immune response to a foreign body. This response is an IgE mediated anaphylaxis inducing the body to manufacture potent chemical mediators that produce symptoms such as hypotension, urticaria, edema, nausea, vomiting, diarrhea, sneezing, and nasal congestion.

Class 2: Type IV – Delayed Hypersensitivity or Contact Dermatitis

Contact dermatitis is a skin irritation caused by chemicals added to the latex during manufacturing or by the glove powder itself. Contact dermatitis is not an allergic reaction.

Type IV Delayed Hypersensitivity is a response mediated by T-cells and characterized by burning, swelling, and the development of debilitating rashes with itching and cracking hands.

Class 3: Non-reactive

Students identified as latex sensitivity high-risk should be counseled to avoid exposure to latex-containing products in the home and work environment. The latex sensitive student should be aware of latex-containing products to avoid and should be advised to seek product information before using a product.

VACCINATION RECORD

A completed vaccination record must be submitted to the Program before the first week of classes. A Licensed Independent Practitioner or his or her representative must complete the date of immunizations or immunity by his or her signature to include:

- Tdap (adolescent/adult)
- Rubeola (measles) – positive titer and/or document 2 MMR vaccinations
  Rubella - positive titer and/or document 1MMR vaccinations
- Mumps - positive titer and/or document 2 MMR vaccinations
- Varicella (chicken pox) - positive titer and/or 2 Varicella vaccinations
- mTB exposure - (may be initiated during time of drug testing for first year students)
- Hepatitis – positive HBs AB titer (if never received complete vaccinations, complete and then titer)
- Influenza- yearly according to sponsoring organization vaccination schedule A form is attached to document the student's vaccination record.

If a student needs a titer or immunization for any of these diseases, the student should contact Occupational Health at (308) 630-1151. If it is determined through a blood test that a student is not immune to the above diseases, a vaccine booster will be offered.

HEALTH

Each student will assume responsibility for managing his or her own health care, health care expenses, and for meeting health requirements

STUDENT HEALTH RECORDS

Student health records shall be maintained by the Program Director and Occupational Health Department and shall become a part of the student's permanent record.

All information in the student's health record is confidential. Latex allergy, influenza vaccine and hepatitis immune status may be released to the Infection Control nurse or student's clinical supervisor on a need to know basis. Other information from a student's health record will be released only within the context of legal demands from insurance or regulatory agencies. Off-campus clinical sites may require documentation of medical information for that facility's records.

Information will be released only with written permission from the student and only to those persons or agencies specified on the written request.

Stephanie Cannon

Digitally signed by Stephanie Cannon
Date: 2021.12.17 14:17:38 -07'00'

Signature
Stephanie Cannon, MSRS, RT(R)(ARRT)
Program Director

Joshua T. Lively

Digitally signed by Joshua T. Lively
Date: 2021.12.18 18:34:57 -07'00'

Signature
Joshua Lively, MHA, BSRT(R), RT (R)(VI)(ARRT)
Director of Imaging Services

Reference: Hospital Policy 206.0.01

Reviewed: 7/31/0, 3/26/03, 6/28/06, 3/29/12, 4/18/13, 3/4/16, 1/27/17, 4/27/20, 9/30/21
Revised: 09/22/88, 04/09/91, 7/16/94, 5/12/95, 6/14/96, 12/29/99, 8/19/00, 1/11/01, 6/26/01, 5/31/04, 1/9/08, 5/10/08, 8/6/10, 11/1/11, 3/29/12, 2/21/2014, 2/6/15, 2/2/18, 1/31/19

REGIONAL WEST MEDICAL CENTER SCHOOL OF RADIOLOGIC TECHNOLOGY

STUDENT INFORMATION FORM

Full Name:

Last *First* *M.I.* *Maiden Name*

Current Address:

Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Sex: ☐ Male ☐ Female Date of Birth _____

Place of Birth

City *State* *ZIP Code*

Cell Phone: **( )** _____ Home Phone **( )** _____

E-mail Address: _____

Social Security Number or Government ID: _____

Permanent Address:

Street Address *Apartment/Unit #*

City *State* *ZIP Code*

High School Attended: _____ Date of Graduation: _____

City *State*

GED Location: _____ Year of GED: _____

Information Requested by the US Department of Education

Racial and Ethnic Origin. Check One.

☐ Non-Resident Alien

☐ Race and Ethnicity Unknown

☐ Hispanic (of any race)

For Non-Hispanics only:

☐ American Indian or Alaskan

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ Two or More Races

I CONSIDER MYSELF:

☐Handicapped If Selected, Reason _____

☐Disadvantaged If Selected, Reason _____

Are you a veteran and receiving G.I. Benefits? ☐ Yes ☐ No

Full Name: _____

Last *First* *M.I.*

Address: _____

Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Primary Phone: **( )** _____ Alternate Phone: **( )** _____

Emergency Contact Information

Full Name:

Last *First* *M.I.*

Address:

Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Primary Phone: **( )** Alternate Phone: **( )**

Relationship:

Licensed Independent Practitioner (Doctor)

Name:

Last *First* *M.I.*

Address:

Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Primary Phone: **( )**

Pertinent Medical Problems

REGIONAL WEST MEDICAL CENTER SCHOOL OF RADIOLOGIC TECHNOLOGY

UPDATE OF STUDENT CONTACT INFORMATION FORM

To be utilized when there is a change to the information given in the above form.

Updated Personal Information

Full Name: _____

Last *First* *M.I.* *Maiden Name*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Cell Phone: **( )** _____ Home Phone: **( )** _____

E-mail Address: _____

CONTRACT EMPLOYEE/STUDENT REQUIREMENTS

Name_____**Department** Imaging Services: School of Radiologic Technology

Urine Drug Test
(Contract employees only—no more than 30 days prior to start of assignment) _____

Current/annual respirator fit test if applicable to department/duties
(KC46767, KC46867, 3M1860, 3M1860S, 3M1870, PAPR type) _____

Record of Varicella IgG Positive/Negative _____
If negative, record of two doses of vaccine #1 _____ Then re-titer _____#2 _____
Or signed Regional West Health Services medical exemption letter _____

Record of Hepatitis B antibody Positive/Negative
If negative, record of 3 doses of vaccine #1 _____#2 _____#3 _____
Then re-titer _____If still negative, record of booster #4 _____
Then re-titer _____ If still negative, record of 2 more doses #5_____#6 _____
Then re-titer _____If still negative, non-converter
Or declination signed _____

Record of Measles IgG Positive/Negative _____
If negative, record of two doses of vaccine #1 _____#2 _____
Then re-titer _____If still negative, record of booster #3_____
Then re-titer _____ If still negative, non-converter
Or signed Regional West Health Services medical exemption letter _____

Record of Mumps IgG Positive/Negative _____
If negative, record of two doses of vaccine #1 _____#2 _____
Then re-titer_____If still negative, record of booster #3 _____
Then re-titer _____If still negative, non-converter
Or signed Regional West Health Services medical exemption letter _____

Record of Rubella IgG Positive/Negative _____
If negative, record of one dose of vaccine #1 _____
Then re-titer_____If still negative, record of booster #2 _____
Then re-titer _____If still negative, non-converter
Or signed Regional West Health Services medical exemption letter _____

Record of Flu vaccination during flu season (usually August through May) _____
Or signed Regional West Health Services medical exemption letter _____

Record of Tuberculosis (TB) testing

TB skin test within last 12 weeks _____**and** within last 12 months _____
OR Quantiferon Gold TB lab test within last 12 weeks _____
If + TB testing, record of negative chest x-ray _____

Record of tetanus, diphtheria, and pertussis (T-dap) vaccination if available _____
(COPIES OF DOCUMENTS MUST BE ATTACHED TO QUALIFY)

Regional West Health Services
308.635.3711 | 4021 Avenue B | Scottsbluff, NE 69361

Contract Employee/Student Requirements
8373.024 02/15
Policy 206.0.01

PHYSICIAN VARICELLA VACCINATION EXEMPTION LETTER

Date_____

Regional West Health Services
4021 Avenue B
Scottsbluff, NE 69361

Attention: Safety and Occupational Health Office

Student's Name_____

The above student is unable to receive the Varicella vaccination due to the following

1. Permanent Exemptions

- ____ Anaphylactic (life-threatening) allergy to gelatin or neomycin.
- ____ Anaphylactic (life-threatening) reaction to a previous Varicella vaccination.
- ____ Chronic steroid use longer than 2 weeks for persons who are immunocompromised or receiving >20 mg/day of prednisone or equivalent.
- ____ Immunodeficiency (for example, cancer or cancer treatment, HIV/AIDS, untreated active tuberculosis).

2. Temporary Exemptions (expected date temporary exemption will end_____)

- ____ Current use of antiviral drugs (for example, acyclovir or valacyclovir) (discontinue use ≥24 hours before administration of Varicella vaccination).
- ____ IG (Immune Globulin), blood, or plasma transfusions (wait 3-11 months before administration of Varicella vaccination).
- ____ Pregnancy (women should not become pregnant within 4 weeks of Varicella vaccination)
- ____ Moderate or severe illnesses, with or without fever, at the time the Varicella vaccination is scheduled.
- ____ Temporary steroid use longer than 2 weeks for persons who are immunocompromised or receiving >20 mg/day of prednisone or equivalent.
- ____ Immunodeficiency (for example, cancer or cancer treatment, HIV/AIDS, untreated active tuberculosis).

Provider Name (please print) _____

Provider Signature _____

Please release the requested information regarding my ability to receive a Varicella vaccination to Regional West Health Services Safety and Occupational Health Department.

_____ _____

Signature of student Date

Note: Please return completed form to RWHS Safety and Occupational Health Office or fax to 630-1180.

Date _____

Regional West Health Services
4021 Avenue B
Scottsbluff, NE 69361

Attention: Safety and Occupational Health Office

Student's Name _____

The above student is unable to receive the inactivated flu vaccination secondary to the following

____ An anaphylactic (life-threatening) reaction to any component of the specific vaccine (if known, list component_____)
____ Guillain-Barre Syndrome (a severe paralytic illness)

If the above criteria are not met, identify which vaccine the employee should receive:
Recombinant Hemagglutinin Influenza Vaccine (RIV3; FluBlok) _____
Cell Culture-based Inactivated Influenza Vaccine (ccIIV3; Flucelvax) _____
Inactivated Influenza Vaccine (Standard) _____

Provider Name (please print) _____

Provider Signature _____

Please release the requested information regarding my ability to receive an influenza vaccination to Regional West Health Services Occupational Health nurses.

_____ _____
Signature of student Date

Note – Please return completed form to RWHS Safety and Occupational Health office or fax to 308-630-1180.