STUDENT HEALTH STATEMENT
Mineral Area College Radiology Program

A health care provider must complete this form.
Exact dates are required for all immunizations and/or test results.

Student’s name: ___________________ M / F Last First MI circle Date of birth: ___/_____/___

Childhood Illness and Dates
☐ Measles _______ ☐ Rubeola _______ ☐ Chicken Pox _______ 
☐ Mumps _______ ☐ Hepatitis _______ ☐ Tuberculosis _______ 
☐ Rubella _______ ☐ Whooping Cough _______ ☐ Other _______

REQUIRED IMMUNIZATIONS

A. MMR (Measles, Mumps, Rubella) 2 doses required (or 1, 2, and 3 below)
   Dose 1 immunized on or after first birthday Date: ___/_____/_____
   Dose 2 given at least one month after dose 1 Date: ___/_____/_____
   OR:
   1. MEASLES (RUBEOLA) If given instead of MMR, 2 doses required
      Dose 1 immunized on or after first birthday Date: ___/_____/_____
      Dose 2 given at least one month after dose 1 Date: ___/_____/_____
      If unable to document 2 Measles Immunization dates must provide:
      Measles serology immune titer value____
      Interpretation: ______ Immune ______ Not Immune Date: ___/_____/_____

   2. MUMPS If given instead of MMR, 1 dose on or after first birthday
      Date: ___/_____/_____
      If unable to document 1 Mumps Immunization date, must provide:
      Mumps serology immune titer value____
      Interpretation: ______ Immune ______ Not Immune Date: ___/_____/_____

   3. RUBELLA If given instead of MMR, 1 dose on or after first birthday
      Date: ___/_____/_____
      If unable to document 1 Rubella Immunization date, must provide:
      Rubella serology immune titer value____
      Interpretation: ______ Immune ______ Not Immune Date: ___/_____/_____

B. TETANUS-DIPHTHERIA Immunization Booster within the past 10 years
   ☐ Td ☐ Tdap Date: ___/_____/_____

C. VARICELLA VACCINE (Chicken Pox) Dose 1: ___/___/___ Dose 2: ___/_____/_____
   OR: Varicella serology immune titer value______ Date: ___/_____/_____
   OR: History of disease Date: ___/_____/_____
SUGGESTED VACCINE

D. HEPATITIS B VACCINE – 3 doses
   Dose 1: ___/____/____ Dose 2: ___/____/____ Dose 3: ___/____/____
   OR: Documentation of a positive antibody titer (HbsAB) ______ Positive ______ Negative
       Date: ___/___/___

E. INFLUENZA
       Date: ___/___/___

To the best of your knowledge, has the applicant demonstrated any illness or symptoms that may be considered a health hazard in performance for the education process or to the health care profession?

☐ Yes ☐ No

In the clinical education phase of the curriculum, the student will be required to do a considerable amount of standing, bending, reaching over their head, lifting, pulling, manipulating mobile x-ray units, assisting patients getting in and out of wheelchairs, assisting patient from a stretcher to a bed or x-ray table, and pushing wheelchairs with patients. Will this applicant be able to perform these requirements without injuring or endangering themselves or patients?

☐ Yes ☐ No

Does this individual have any communicable disease which may be hazardous to patient or fellow students?

☐ Yes ☐ No

Do you feel this applicant has sufficient visual and aural activity to communicate effectively with patients and other staff?

☐ Yes ☐ No

Students are required to have documentation of any past immunizations or history of disease with this form. The documentation may be from high school records, Public Health Records, and/or Physician’s Office. **Any required booster should be given at this time.**

An annual PPD test is required while enrolled in the Program. The student should have this test completed **BEFORE** the first day of clinical and will have it repeated the following August while enrolled in the Radiology Program at Mineral Area College.

Students selected into the program will undergo a criminal history background check and a drug test.

COMMENTS:

HEALTH CARE PROVIDER

Name (Please print) __________________________________________

Signature ________________________________________________

Address _________________________________________________

Phone (_____) __________________ Fax (_____) ________________