

**JEFFERSON COMMUNITY COLLEGE  
ASSOCIATE DEGREE IN RADIOLOGIC TECHNOLOGY**

Student Immunization and Health Record Policy

Please read carefully. This policy contains information regarding immunizations and health records required for enrollment in the Radiologic Technology Program at Jefferson Community College. All requirements outlined below must be met in order to remain enrolled in the program. This will include: 1) liability insurance, 2) CPR, and 3) immunizations. Documentation is required. **Failure to comply with these requirements may result in dismissal from the Radiologic Technology Program.**

**The requirements are:**

**1. Liability Insurance**

Submit a **money order** or **certified check** made payable to the KCTCS in the amount of \$20.00 exactly.

Attach the money order or certified check to the liability insurance application enclosed or available from Allied Health Division Secretary's Office in LV 320.

**DO NOT BRING A PERSONAL CHECK OR CASH TO COVER THE \$20.00 FEE.  
PERSONAL CHECKS WILL NOT BE PROCESSED.**

**2. CPR:** Certification in CPR (Cardiopulmonary Resuscitation) is required for all radiography students. A copy of a CPR card verifying certification through at least May 2001 (or proof of registration in a CPR class that will be held in August must be submitted). Certification may be obtained through the American Heart Association, American Red Cross, or at area hospitals and churches. Be sure that you take CPR classes designed for **health care providers** and include: one-man and two-man CPR and obstructed airway. The CPR & Obstructed Airway instruction must include variations for infants, children & adults.

**3. Immunization/Health Record:**

Acceptable documentation includes one of the following:

- (1) A copy of the medical record documenting diagnosis of the illness. This is only acceptable for those conditions whereby having the illness can result in natural immunity.
- (2) A physician or nurse's signature verifying that the student received the appropriate vaccination(s). The signature must be placed on the appropriate space on the enclosed immunization form. Additional forms can be obtained from a program faculty member.
- (3) Xeroxed copies of any lab test(s), chest x-ray report, etc.

**Do not submit original individual copies. Try to consolidate as much as possible on each sheet of xeroxed information.**

- (4) Copy of your J.C.P.S. High School diploma will prove that you had childhood immunization. You will still need to provide documentation of an MMR after age 12, Td within the past 10 years and a PPD that is current throughout the academic year.

Unacceptable documentation:

- (1) Except for Pertussis and Varicella, personal statements by anyone including a parent or guardian that the student has had the illness as a child or adult will be unacceptable and will not be accepted as documentation.

#### **4. PPD (Tuberculosis Test)**

We will accept results of the tine, Mantoux or a chest x-ray as verification of tuberculin status. **This test must be done once a year** and will be required upon entry to the Radiologic Technology Program and renewed during the summer semester of the program.

If you submit a tine or Mantoux result, **you must provide the date the test was done, the date the result was read and the signature of the nurse or physician documenting the result.**

If you have a chest x-ray, submit a copy of the radiology report.

**If either the PPD or chest x-ray result is a positive reading, you must document medical follow up. A doctor's written statement is required.**

#### **5. TETANUS (Td)**

Documentation of a Td within the last 10 years. If the student has never had a Td, he/she must provide documentation of a primary DPT series (as infant), or an adult series of Td. The primary childhood series consist of 3 doses of DPT and a booster. After the age of 7, the DPT is no longer given. The Td (DT) is the adult form of this immunization. If you are not able to document the childhood series, then you **MUST** complete the adult Td series. The adult series of the Td must include 3 doses of Td, the first two given 6 to 8 weeks apart and the third, six months after the second dose. The third dose, however, must have been received within the last 10 years. A Td booster is required every 10 years, except if an injury occurs, then 5 years.

#### **6. VARICELLA (Chicken Pox)**

Personal history of an active case of Varicella, or documentation of a physician - diagnosed case of Varicella will be accepted. The parent, guardian, or health care professional providing the information must sign the Personal History Verification form. A Varicella titer showing immunity will also be accepted.

Non-immune individuals will not be allowed to care for patients with Varicella. If a non-immune individual sustains an exposure to Varicella, he/she will be restricted

from clinical rotations from day ten post-exposure through day twenty-one post exposure.

## 7. PERTUSSIS

Personal history of an active case of Pertussis will be accepted. The parent or guardian providing the historical information must sign the Personal History Verification form. A copy of the medical record verifying the diagnosis of the illness or receipt of the vaccination series will also be accepted.

## 8. MMR (Measles - Mumps - Rubella)

MMR (Measles - Mumps - Rubella) trivalent vaccine is the vaccine of choice, and as such is recommended for use by the Centers for Disease Control (CDC). The student must provide appropriate documentation of one of the following: two Measles (Rubeola), one Rubella and one mumps; or two doses of MMR given after the age of twelve months.

1) Two Measles, one Rubella, and one mumps immunization

Or

2) Two doses of MMR given after the age of 12 months.

Or

3) Even though CDC Guidelines states that persons born before 1957 should be considered immune, health care workers (e.g. nursing, radiography students) are a high exposure group; therefore, CDC recommends one dose of MMR for those born before 1957 who cannot provide proof of immunity to this disease by documentation of a physician diagnosed case of measles, mumps, rubella.

Or

4) A copy of the medical records documenting diagnosed measles, mumps, or rubella as proof of immunity.

Or

5) Results of the following titers: Measles IgG, Mumps IgG and Rubella Titer.

9. A **Physician's Medical Release** will be required if you are pregnant, have back problems or have Diabetes Mellitus. The release should describe specific limitations, if any, that the student needs to adhere to. \*Review and sign the form, which indicates awareness of the technical standards required for the radiologic technology program at Jefferson Community College.

10. The Hepatitis B Vaccine series is strongly encouraged.

11. The Influenza vaccine is recommended for persons with chronic, debilitating conditions or prone to the flu.

Please contact the Clinical Coordinator if you have questions or concerns regarding this policy. All students are expected to comply with the requirements outlined in order to remain enrolled in the radiologic technology program.

NAME: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

**IMMUNIZATION RECORD FOR J.C.C. RADIOLOGIC TECHNOLOGY PROGRAM**  
Tuberculosis Testing

We must have your health care provider's signature in the appropriate space or copies of the actual immunization forms attached to this form.

	<u>Fall / Spring</u>		<u>Fall / Spring</u>
PPD (Tine/Mantoux)	_____ / _____	_____ / _____	_____ / _____
<b>*(IMPORTANT)</b>	*date received	(signature)	(signature)
	_____ / _____	_____ / _____	_____ / _____
	*Date read	(signature)	(signature)
	_____ / _____	_____ / _____	_____ / _____
	*MM induration	(signature)	(signature)
<b>OR</b>			
Chest x-ray	_____ / _____	_____ / _____	_____ / _____
(Attach	*date received	(signature)	(signature)
Report)	_____ / _____	_____ / _____	_____ / _____
	*Results	(signature)	(signature)

Must be current for the full semester. If (+) then documentation of medical follow-up is required by the physician.

DIPHTHERIA / PERTUSSIS/TETANUS

(APPROPRIATE SPACES)		DATE	SIGNATURE MD/RN
Childhood:			
Diphtheria	2 mo. _____	_____	_____
	4 mo. _____	_____	_____
	6 mo. _____	_____	_____
	4 y/o _____	_____	_____
Pertussis	2 mo. _____	_____	_____
	4 mo. _____	_____	_____
	6 mo. _____	_____	_____
	4 y/o _____	_____	_____
Tetanus	2 mo. _____	_____	_____
	4 mo. _____	_____	_____
	6 mo. _____	_____	_____
After 7 years of age:			
Adult *Td.:	_____	_____	_____

\*If you have not received a primary series as a child then you must complete a primary series for adults. This primary series for child consist of three doses of DPT plus a booster. A primary series of Td for an adult consists of the three doses, the first two are given 6 to 8 weeks apart and the third given 6 months after the second. The last dose must have been given within the last 10 years.

\*\* If you have not been immunized or do not have a history of Pertussis (Whooping Cough) you must wear a mask in the clinical area when providing care for a child with Pertussis. Hospital's protocol for Pertussis exposure must be complied with if exposure occurs.



**PERSONAL HISTORY VERIFICATION FORM**

**CHICKEN POX (Varicella)**

\_\_\_\_\_ I do or a family member does recall my having Chicken Pox as a child.

\_\_\_\_\_ I do NOT nor does a family member recall my having Chicken Pox as a child.

**WHOOPING COUGH (Pertussis)**

\_\_\_\_\_ I do or a family member does recall my having Whooping Cough as a child.

\_\_\_\_\_ I do NOT nor does a family member recall my having Whooping Cough as a child.

(Student Signature)

\_\_\_\_\_  
(Printed Name of Student)

\_\_\_\_\_  
(Family Member Signature, if applicable)

DAP: Revised 4/01

**KCTCS**  
**Jefferson Community College**  
**DECLINATION FORM**  
**Hepatitis B Vaccination**

I understand that as a student enrolled in the Jefferson Community College Radiologic Technology Program, I may be exposed to infectious diseases or blood-borne pathogens such as the Hepatitis B Virus. I further understand that as a result of this exposure, I may acquire the Hepatitis B Virus or another infectious disease.

The Radiologic Technology Faculty and Jefferson Community College strongly recommend that I receive the Hepatitis B Vaccination.

Even though I have been informed of the potential risk, I decline to receive the vaccination at this time.

I realize that by declining to have the Vaccination, my clinical experiences may be limited/refused. Jefferson Community College does not accept any responsibility for this, because the immunization policy is a requirement of the affiliating clinical agencies and not that of the University.

I further realize that without the immunization, I remain at risk for acquiring the disease for which the immunization is indicated. Jefferson Community College Radiologic Technology Program will not assume any cost or charges if I decide to receive the immunization now or in the future.

Date: \_\_\_\_\_ Name: \_\_\_\_\_