



RESPIRATORY CARE PROGRAM CHECKLIST

New Applicants

Required to Apply to Program:

Application for Program Admissions
Official College Transcript
College Degrees/Certifications (if applicable)
High School Diploma (copy or transcript)
Prerequisites (BIOL 2301, MATH 1342, and ENGL 1301) MATH 1314 or higher will be accepted instead of required MATH 1342
Application Letter (<u>hand-written</u> , not typed) “Why I am interested in Respiratory Care”
One Letter of Recommendation

After Accepted into the Program, the following is required:

Castle Branch - Background Check, Drug Test, and Medical Document Manager (Purchase required Package TF76im) https://portal.castlebranch.com/TF76/spif/TF76/TF76im
Immunization Records:
- 1 st Year TB (PPD) Test or TB Chest X – Ray
- MMR #1 , & #2
- Tdap
- Varicella Vaccine : #1, & #2, or Chicken Pox Illness Date
- Hepatitis B: #1, #2, #3, or Booster
- Influenza Vaccine (obtain during flu season newest vaccine for that year)
- Meningitis (Exempt if student is 22 years of age or older)
CPR/ Certified by American Heart Association
Physical Exam (consist 3 medical documents to be completed)
Data Arc - www.dataarcc.ws

APPLICATION FOR PROGRAM ADMISSIONS

Select Program of Interest:

- Diagnostic Medical Sonography *Radiologic Technology Emergency Medical Science
 *Respiratory Care Science Medical Laboratory Technology

This application is for admission into the program beginning: FALL _____ / SPRING _____

** NOTE: Applicants must complete remedial requirements & program prerequisites by the application deadline of the term for which admission is sought.*

Date of Application: _____ Student ID #: _____

Full Legal Name: _____
Last First Middle

Current mailing address: _____
Street
City State Zip

Current telephone: () _____ (where you can be reached between 8 a.m. and 5 p.m. on weekdays)

Email Address: _____

If you have previously attended any school under a name other than that given above, please specify below:

List other Allied Health Schools/Programs you have or will apply to:

Allied Health School

Date of Application

PERSONAL INFORMATION

Male Female

Place of Birth: _____

Ethnic Origin: (OPTIONAL-for affirmative action purposes only)

- White Hispanic Native American Prefer Not To Answer
 Black Asian International

Emergency Contact:

Name Relationship

Street Address

City, State, Zip Telephone

Have you ever been convicted of a misdemeanor or felony (including deferred adjudication for either) with the exception of minor traffic violations (e.g. speeding or parking violations)? *Note: DUI's, DWI's, PI's are not minor traffic violations. Yes No
If "Yes," provide a written explanation.

Were you ever required to leave high school, college, graduate or professional school or ever denied readmission because of deficiencies either in conduct or scholarship? Yes No If "Yes," provide a written explanation.

In order to provide better services for people with disabilities, the following voluntary information is needed. This is for affirmative action purposes. The information you provide will not affect your admission to the School of Health Sciences and will be kept confidential.

Please check all that applies to you: physical disability learning disability other disability
Will you need accommodations in order to succeed in the program for which you are applying? yes no

EDUCATIONAL BACKGROUND

Student Health, Immunization and Communicable Diseases Policy

The students will follow the guidelines set forth by TSC, the clinical sites, the Centers for Disease control, Occupational Safety and Health Administration (OSHA), and any other regulatory agency affiliated with both TSC and the practicum affiliates.

GUIDELINES:

1. Students are financially responsible for their personal health care/hospitalization costs incurred while participating in the Respiratory Care Science Program.
2. Students must obtain a physical exam and submit it to the Respiratory Care Science Program before beginning clinicals. Students are required to maintain current immunizations. This includes yearly TB testing, yearly flu shots, Hepatitis B vaccine series, tetanus (every 10 yrs.), and other routine childhood immunizations. Students must be current on appropriate immunizations to be allowed in the clinical sites. For this reason, all required records must be submitted prior to the first clinical semester.
3. **If a student is unable to meet clinical objectives due to the presence of a communicable disease, a passing clinical grade cannot be obtained.**
4. In the event that a student becomes exposed to a communicable disease, the following procedures are recommended: (Hepatitis, Tuberculosis, Mumps, Measles, etc.)
 - a. Report exposure to clinical instructor, authorities in health care agencies, and educational institution.
 - b. Assess the clinical status of the source-client.
 - c. Test the exposed individual soon after possible exposure.
 - d. Retest in 6 weeks, 3, 6, and 12 month intervals with a private physician
 - e. Seek counseling and adhere to the recommendations for the prevention of transmission of infections or communicable diseases.
 - f. Confidentiality of medical records is protected and information is shared only on a strictest “need to know” basis.
 - g. Confidential screening for various communicable diseases can be obtained through the Cameron County Health Department.

**TEXAS SOUTHMOST COLLEGE
GENERAL PHYSICAL EXAM**

As a minimum requirement, this physical exam form must be completed yearly prior to participation in any participation in any practice or game/matches

Full Name _____ Birth Date _____ Age _____ Sex _____

ID# _____

Height _____ Weight _____ %Body Fat (optional) _____ Pulse _____ B/P _____ / _____ (____/____)

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

* station-based examination only

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendation: _____

The following must be filled in and signed by a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an advanced Practice Nurse by the Board of Nurse Examiners.

Name (print/type) _____ Date Examination _____

Address: _____

Phone Number: _____

Signature: _____

Report of Health Evaluation

TO THE EXAMINING PHYSICIAN: Please review the students' history and complete the physician forms. Please comment on all positive answers. This information will be used only as a background for providing health care, if necessary.

Student Name:		
Blood Pressure	Height	Weight in pounds

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS?			
SYSTEM	YES	NO	COMMENTS
Head/Ears/Nose/Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Gynecological/OB			
Are there any speech/vision/hearing impairments?			
Eyes			Vision: Lt. Rt. Corrected:
Hearing			Hearing: Lt. Rt. Corrected:

In my opinion, is this individual in suitable physical and emotional condition for this Allied Health Program?

Unlimited Limited Please explain: _____

Physician's Signature _____
Date

Print Physician's Name _____
Business Number

Address City State Zip

Allied Health Programs

Report of Medical History

Last Name:	First:	Middle:	Maiden:
Address			
Phone			Date of Birth

Emergency Notification

Person to notify in case of emergency

Last Name:	First:	Middle:
Address		
Home Phone	Work Phone	Relationship

Personal History

ANSWER ALL QUESTIONS. EXPLAIN "YES" ANSWERS BELOW:

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
Measles			Seizures		
Mumps			Dizziness, Fainting		
Rubella			Weakness, Paralysis		
Chicken Pox			Joint Problems		
Diabetes			Back Problems		
Tuberculosis			Gastrointestinal Problems		
Hepatitis A/B/C			Heart Problems		
Visual Impairment			Malignancy		
Hearing Impairment			Respiratory Problems		
Surgery			Hernia		
Recurrent Headache			Allergies		
Any UNEXPLAINED weight loss (greater than 10 pounds)?					
Have you had any illness/injury or been hospitalized other than already noted					
Is your ability to practice safe professional medical care adversely affected by a physical or mental disability/illness which may endanger the health and safety of persons under your care?					

EXPLAIN "YES" ANSWERS: _____

Student Signature

Date



Respiratory Care Student Credit Card Order Form

To process your order the following information is needed.

Contact Information	
Name	
Email Address	
Phone Number	
Shipping Address	
Payment Information	
Credit Card Type	<input type="radio"/> Discover <input type="radio"/> Master Card <input type="radio"/> Visa
Name on Card	
Card Number	
Expiration Date	
Your Mailing Address for Credit Card Statements	
Program Information	
Name of Program	
CoARC #	

Number of Student Licenses (1 per student @ \$60.00 each)	#___ of Licenses x \$60.00	
	UPS Shipping and Handling (1-25 CD's \$10.00; 26-50 CD's \$15.00)	
	Total Purchase Price	

Orders can be sent to DataArc in the following formats:

Mailed to: DataArc, LLC
 2951 Marina Bay Dr. 130-355
 League City, TX 77573

Fax to: (281)538-8972

Email to: orders@dataarc.ws

DataArc, LLC Tax ID: 76-0653886
 Phone: 1-(866)328-2552
 Fax: (281)538-8972

Thank you for your interest and we look forward to continuing your services.