



Medical Center Campus
 School of Health Sciences
 Radiography Program

Students Name: _____ Class of _____

Documentation Check List		On File
1.	Background Check Acknowledgement	
2.	Copy of Current CPR Card (8 hrs.)	
3.	Copy of HIV/AIDS Certificate (4 hrs.)	
4.	Emergency Contact Form	
5.	Health Physical Form	
6.	Hepatitis B Vaccine Form (HBV) or Declination Form	
7.	Medical Accident Insurance Form	
8.	Program Orientation Information Signature Sheet	
9.	Proof of Medical Insurance	
10.	Release/Consent Form (Health Record)	
11.	Release/Consent Form (MDC SHC Student Manual)	
12.	Student Fact Sheet	
13.	Completed forms from the Student Manual: <ul style="list-style-type: none"> • Release/Consent Form • Student Confidentiality Statement • Acknowledgement of receiving School of Health Sciences Student Manual • Acknowledgement and Consent for Release of Information 	

All the forms for item 13 are from the Student Manual which can be obtained from the Miami Dade College, Medical Campus Website by going to School of Health Sciences. Student must read and complete all the forms in the Student Manual and bring them on Orientation Day.

Verified by: _____ Date: _____



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Student Fact Sheet

Student ID Number: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Alternate Contact (Name and Phone): _____

E-mail Address: _____

Gender: Male: _____ Female: _____

Marital Status: Single: _____ Married: _____ Divorced: _____ Separated: _____ Widowed: _____

Date of Birth: _____ Age: _____ No. Dependents: _____

Ethnicity (Based on Department of Education Categories)

	American Indian or Alaskan Native
	Asian or Pacific Islander
	Black Non-Hispanic
	Mexican American
	Puerto Rican
	Hispanic Other
	White

Do you receive any type of Financial Aid such as Scholarship? Loan, PIC, or Grant?

Yes: _____ No: _____

Have you ever worked in the Health Care Field?

Yes: _____ No: _____

Do you own or have access to an off campus computer with internet access?

Yes: _____ No: _____



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Emergency Contact

Date: _____

Name: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Fax Number: _____

Other: _____

E-mail Address: _____

Who else can we call to get in touch with you?

Relation: _____



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Program Handbook

I have received the Radiography Program Student Handbook at Miami Dade College.

I agree to abide by the Policies and Procedures of the program and the Clinical sites I rotate through.

Print Name: _____

Student Signature: _____

Date: _____



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Document Release form

I (print student name) _____ give permission to the Radiography Program to release my health records to the Clinical education Site that I am assigned to for clinical practice, for the duration of the Radiography program. My health records may also be released to any other Clinical education Sites for Specialty Clinical Experiences during the course of the program. I acknowledge that without this authorization I will not be allowed to participate in any clinical rotation or be part of the Radiography Program.

Student Signature: _____ Date: _____

Clinical Coordinator's Signature: _____ Date: _____



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Medical Accident Insurance

Students in the Health Sciences and Nursing programs are at risk of exposure to infected blood and body secretions. Students are required to purchase medical accident insurance for treatment that may be necessary as a result of unexpected exposure to infectious materials. Coverage is provided through the Florida Community Colleges' Risk Management Consortium. Students are required to purchase this coverage once each academic year. A special fee is assessed at the time of the registration. In addition, students are encouraged to carry their own personal health insurance.

I have read and understand the need for Medical Accident Insurance while in the Health Sciences program at MDC.

Student Signature: _____ Date: _____

Print Name: _____ Student Number: _____