TEMPLE COLLEGE
TEMPLE HUTTO TAYLOR

Please complete & leave this FORM with the person leading the session.

Department of Respiratory Care
Preadmission Form

Date _____

Personal Data (*Please complete all *'s in this section*):

_____
*Last Name *First Name *Middle Name (not initial) *Home Phone

_____
*Address *Apt. # Work Phone

_____
*City *State *Zip *Cell Phone

*Email: _____

EDUCATION:

_____ _____ _____ _____
High School Location Diploma/GED Date

_____ _____ _____
College/University/Professional School Degree/Cert/Hrs. Date(s)

_____ _____ _____
College/University/Professional Degree/Cert/Hrs. Date(s)

OTHER INFORMATION

Please respond to the following as accurately as possible. Have you:

1. Made application for Admission to Temple College? _____ Yes/No
2. Complete TSI? _____ Yes/No If yes, what were your scores: _____ R _____ W _____ M
3. Completed the program's prerequisites: BIOL 2401 _____ Grade, ENG 1301 _____ Grade, Social/Behavioral Science _____ Grade
4. Complete the Respiratory Care Program's Aptitude Test (most current TEAS Test)? _____ Yes/No
5. Please explain briefly why you may be interested in a career in Respiratory Care.

_____
_____
_____

_____ _____
Prospective Student's Signature Instructor's Signature

Temple College is committed to nondiscrimination practices based upon race, gender, gender identity and expression, disability, age, religion, national origin, genetic information, or veteran status.

Revised: 06/06/2023

Please Complete This Page and Leave with the Instructor of Info Session.

TEMPLE COLLEGE
Department of Respiratory Care

SCHOOL/PROGRAM CHOICE

_____ _____

Name (PRINT) Today's Date

Please answer the following two questions as completely as possible. These answers are anonymous and will only be used to study prospective students' choice influences. Thanks!

1. Explain the most important factor in selecting a school to attend for you at the present time.

_____

_____

_____

_____

2. Explain the most important factor that has/will influence you to select a particular program of study.

_____

_____

_____

_____

TEMPLE COLLEGE
DEPARTMENT OF RESPIRATORY CARE
PROSPECTIVE STUDENT HOSPITAL TOUR

_____ Fall _____ Admission
Applicant Name (Please PRINT) (year of interest)

Email: _____

Ph/Cell # _____

In order for prospective students to more adequately evaluate whether or not they may be interested in the respiratory care profession we require each prospective student to complete a brief hospital tour at Baylor Scott & White Hospital.

The tour is usually set up on the same day as the information session. The tour guide will likely be *David Fry, RSPT Instructor and Department Chair* or someone else at BSW. If Mr. Fry is not available, you will be given instructions where to meet at Baylor Scott & White.

Be sure you bring/email (debbie.parten@templejc.edu) this competed FORM back to us at the Health Science Center, to be placed in your file. If you have any questions call the TC Respiratory Care Office at (254) 298-8697 or David Fry at (254) 298-8929.

I have completed the tour at Baylor Scott & White Hospital

_____ _____
Applicant's Signature Date

_____ _____
Scott & White Tour Guide Signature Date

Mail/Return this completed FORM to:
Temple College: Respiratory Care Dept.
2600 South First Street
Temple, Texas 76504
or Email FORM to
debbie.parten@templejc.edu

Temple College Respiratory Care Program
ESSENTIAL TECHNICAL STANDARDS & QUALIFICATIONS

Applicant Name: _____ Date: _____

The following physical criteria are requisites for minimal skills related to the Respiratory Care profession. By signing this form, applicant acknowledges they are physically capable to perform at the levels described below and any deficits may affect their ability to progress successfully through the Temple College Respiratory Care Program.

Standard	Issues	Examples of Required Activities
Critical Thinking Skills sufficient to make clinical judgment.	Critical Thinking	Assess patients' physical and psychosocial needs in a variety of clinical settings by utilizing interpretation of written, verbal and sensory observations to determine appropriate therapies for patient care.
Problem solving skills appropriate to adjust therapies in response to patient needs	Problem Solving	Adjust therapeutic interventions to meet the needs of patients in a variety of settings
Interpersonal skills sufficient to allow appropriate interaction with individuals and groups from a variety of cultural and socioeconomic backgrounds.	Interpersonal Relationships	Interacting with patients, families, co-workers and others to create and maintain professional relationships
Written and verbal communication that is appropriate to create clear and concise dialogue in a clinical setting	Communication	Communicate effectively with patients, physicians, families and other staff members to assure appropriate patient care.
Physical abilities appropriate to maneuver in small spaces while maneuvering equipment	Mobility	Move safely in a patients' room. Safely maneuver equipment and apply equipment to patients in a variety of situations often in confined spaces. Perform CPR including chest compressions and intubation
Gross and fine motor skills appropriate to perform patient care procedures to national standards which include safety and efficiency	Motor Skills	Safely care for patients by manipulating machine controls and equipment. Occasionally crouching, squatting or bending to obtain/evaluate equipment and patients: assist patients from lying to sitting and or standing positions; hand eye coordination sufficient to perform an arterial blood gas puncture and suctioning

Appropriate physical strength and endurance to be able to access patient as well as perform therapies on patients for extended periods of time	Strength and Endurance	Transporting patients and equipment within a facility; standing or being mobile in clinical settings for 6 hours or more; strength to perform intubation and assist in moving of patients in beds on stretchers and wheelchairs. Constant standing walking and lifting of up to 20 pounds
Auditory ability sufficient to monitor and assess health care needs of patients	Hearing	Hear monitor alarms, equipment audible alarms, voices with background noise and through protective equipment, calls for help
Tactile ability appropriate for assessment of physical health conditions	Tactile	Be able to palpate patient pulses. Perform didactic and therapeutic percussion and physical assessment of the chest
Ability to deal effectively with stressful situations and maintain a professional and positive interactions with others	Temperament	Perform procedures on patients who are in pain due to a variety of reasons. Maintain a sense of professional behavior when under stress

I, _____, have read the above Essential Technical Standards and Qualifications for the Respiratory Care Profession and do hereby state that I am in compliance with these standards. I fully understand that deficits in any of these areas may affect my performance and ability to successfully complete the Temple College Respiratory Care Program. If I or department faculty believe, now or at any future time, that my physical condition is deficient, in any of the above areas, I will discuss the matter immediately with the Respiratory Care Program Director, the department faculty, and/or seek medical advice from my health care professional.

Signature: _____ Date: _____

TEMPLE COLLEGE
TEMPLE HUTTO TAYLOR

HEALTH EVALUATION FORM

(COMPLETED FORM MUST BE TURNED IN TO RESPIRATORY CARE DEPT. BY 1ST DAY OF CLASS.)

Respiratory Care Student Information:

Date of Birth: _____

Please Print

Last Name	First Name	Middle Name (not initial)	Maiden
Address	City	State	Zip
Phone Number:	email:		

THE FOLLOWING SECTIONS MUST BE COMPLETED BY YOUR PRIMARY CARE PROVIDER.

Please review the student's History, perform a physical exam and complete the Health Evaluation portion of the Form. Identify any problems in the following areas and indicate Yes if there are any, or No if there are none.

Sex: Male___ Female___ Height _____ inches Weight _____(lbs.) Blood Pressure _____ Pulse _____

Head, ears, nose throat	Yes or No	Genitourinary	Yes or No
Respiratory	Yes or No	Musculoskeletal	Yes or No
Cardiovascular	Yes or No	Metabolic/Endocrine	Yes or No
Gastrointestinal	Yes or No	Neurological	Yes or No
Hernia	Yes or No	Skin	Yes or No
Eyes	Yes or No	Psychiatric/Emotional	Yes or No

If any problems are present, would they create a limitation for working in health care? ___Yes ___ No, if yes please explain:

_____

_____

Tuberculosis: **must** show proof of:	
A. Tuberculin Skin Test: **REQUIRED ANNUALLY** and within 90 days of Dr's. exam, OR	Date: _____ Positive _____ Negative _____
B. Chest X-ray (required IF skin test is positive) Must provide signed documentation of results	Date: _____ X-ray results: _____

MMR: Date of Vaccination _____

A. Two doses of measles vaccine required:
Date: _____
Date: _____

Tetanus: Date of Vaccination _____ (cannot expire while in the RC program)

Meningitis: Date of Vaccination _____ (only needed if 21 yrs of age or younger)

Varicella: Date of Vaccination _____ OR

(If you had chickenpox as a child your parent may submit a note stating the month/year you had chickenpox, signed and dated.)

Coronavirus (Covid 19): Date #1 _____

Note: Required by Clinical Rotation Sites Date #2 _____

Influenza (Flu): Date: _____
Note: Must be current season's vaccine

Hepatitis B: must show proof of:

A. Three doses of vaccine administered over a period of 6 months. Initial vaccine followed by 1- and 6-months vaccines respectively OR	Date #1 _____ (MUST Have by June 1st for fall admittance) Date #2 _____ Date #3 _____
B. Serologic test positive for Hepatitis B antibody	Date _____ Result _____

Primary Care Provider Information

Printed Name:

Address: _____

City/State/Zip: _____

_____ _____
Physician's Signature Date

_____
Physician's Printed Name

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