



# DIETETIC TECHNICIAN TECHNICAL ABILITY STANDARDS

Students matriculating in and graduating from any Parkland College health career program must be able to meet the technical requirements of the academic program and must not pose a threat to the well-being of patients, other students, staff, or themselves.

As an incoming DT student, you will need, at a minimum, the following types of skills and abilities:

1. The ability to follow the American Dietetics Association code of ethics.
2. Sufficient body strength to perform medium work level to include frequent lifting 25 pounds above head level on a daily basis.
3. The ability and willingness to perform fine skilled movement activities requiring finger dexterity and eye-hand coordination such as dressing, personal hygiene, grooming, food preparation, and written communication skills.
4. Functional visual ability with correction, if needed, sufficient to read printed material.
5. Functional auditory acuity with correction, if needed, sufficient to comprehend one or more persons engaged in conversational speech.
6. The ability to use the English language at a 12th grade level to communicate effectively in a coherent manner, both orally and in writing, with individuals in all professions and social levels. The ability to gather, analyze, and draw conclusions from data.
7. The ability to effectively write nutrition teaching materials for a broad range of clients, the ability to master basic computer skills, the ability to work in a diverse community, and the willingness to learn how other ethnic groups relate to food.
8. The ability to learn and work effectively in both independent and collaborative situations and the ability to maintain professionalism while getting constructive feedback from staff and instructors.
9. The ability to remember and interpret observations and events, solve problems, and deal effectively with a variety of concrete and abstract variables in situations where limited standardization exists.
10. The ability to adapt effectively to fluctuations in emotional and physical stress levels to include changes in environments, routines, and work loads.
11. The ability to maintain composure when subjected to moderate to high stress levels to include emergency situations.
12. The ability to access transportation to attend classes and clinical internship sites in a timely manner.
13. The willingness to participate in professional activities.

**FOR OFFICE USE ONLY**

Incomplete   
Date deficiency  
letter sent:

Complete   
Reviewed by:  
Date:

Entered   
Entered by:

I give my consent for this health record (Parts I, II, and III) to be reviewed by the program director and released to clinical agencies for compliance audits.

Student's Signature \_\_\_\_\_

Date \_\_\_\_\_

**PART I:** *To be completed by the student (please print).*

CHECK YOUR PROGRAM:

- CMA  DHG  DT  MSG  NUR  
 OTA  RTT  SUR  VTT  XRA

Name (print — last, first, middle)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Local street address		
City	Zip code	Telephone
ID number		Birth date

**MEDICAL HISTORY**

Please check which of the following problems you now have or have had, and if possible, indicate the year.

- Tuberculosis \_\_\_\_\_
- Diabetes \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- Cancer \_\_\_\_\_
- Ulcer \_\_\_\_\_
- Lung disease \_\_\_\_\_
- Kidney disease \_\_\_\_\_
- Blood disorder \_\_\_\_\_
- Seizure \_\_\_\_\_
- Skin allergies \_\_\_\_\_
- Asthma \_\_\_\_\_
- Heart disease \_\_\_\_\_
- Back trouble \_\_\_\_\_
- Shortness of breath \_\_\_\_\_
- Fainting or dizzy spells \_\_\_\_\_
- Head or spinal injuries \_\_\_\_\_
- Liver disease \_\_\_\_\_
- Headaches \_\_\_\_\_
- Measles \_\_\_\_\_
- Mumps \_\_\_\_\_
- Rubella (German measles) \_\_\_\_\_
- Chicken pox \_\_\_\_\_
- Other (specify) \_\_\_\_\_

**PART II:** *To be completed and signed by a health care provider. All dates must include month, day, year.*

**MEASLES (RUBEOLA) — required for all programs**

Persons born prior to 1957 are considered to be immune to measles.

- Immunization with live virus vaccine:  
Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_  
*(two doses given at least 30 days apart; both doses given on or after January 1, 1968, and given on or after first birthday)*

**or**

- Immunity confirmed by blood titer:  
Date of test \_\_\_\_\_ Result \_\_\_\_\_  
*(attach copy of laboratory report)*

**MUMPS — required for all programs**

Persons born prior to 1957 are considered to be immune to mumps.

- Immunization with live virus vaccine:  
Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_  
*(given in 1969 or later and given on or after first birthday)*

**or**

- Immunity confirmed by blood titer:  
Date of test \_\_\_\_\_ Result \_\_\_\_\_  
*(attach copy of laboratory report)*

**RUBELLA (GERMAN MEASLES) — required for all programs**

- Immunization with live virus vaccine:  
Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_  
*(given in June 1969 or later and on or after first birthday)*

**or**

- Immunity confirmed by blood titer:  
Date of test \_\_\_\_\_ Result \_\_\_\_\_  
*(attach copy of laboratory report)*

**TETANUS AND DIPHTHERIA — not required but recommended for all programs**

Date of most recent booster \_\_\_\_\_

Name (print) \_\_\_\_\_  
ID number \_\_\_\_\_

**VARICELLA (CHICKEN POX) — titer required for CMA, DT, MSG, NUR, OTA, RTT, SUR, and XRA programs only**

1. Immunity confirmed by blood titer:  
Date of test \_\_\_\_\_ Result \_\_\_\_\_  
*(attach copy of laboratory report)*

**or**

2. Varicella immunizations (if titer negative)  
Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_

**HEPATITIS A VACCINE — required for DT students.**

Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_

**HEPATITIS B VACCINE — required for CMA, DHG, DT, MSG, NUR, OTA, RTT, SUR, and XRA programs and highly recommended for all others. Postvaccination testing for serologic response (titer) is highly recommended.**

Dose #1 Date \_\_\_\_\_  
Dose #2 Date \_\_\_\_\_  
Dose #3 Date \_\_\_\_\_

Immunity confirmed by blood titer:  
Date of test \_\_\_\_\_ Result \_\_\_\_\_  
*(attach copy of laboratory report)*

**RABIES VACCINATION — required for VTT students**

Dose #1 Date \_\_\_\_\_  
Dose #2 Date \_\_\_\_\_  
Dose #3 Date \_\_\_\_\_

**TUBERCULOSIS SCREENING — initial 2-step TB test (must be Mantoux; TB tine tests are not acceptable) required for all programs**

Tests must be performed within 9 months prior to the student starting the program. After initial testing, a yearly single-step Mantoux test is required for all programs except VTT. If the student has a positive TB test, a chest x-ray must be performed and a copy of the report attached to this record.

1. Has student ever had a positive TB skin test?  
 No (go to #2)     Yes (year) \_\_\_\_\_  
 If yes, medication was not prescribed  
 If yes, medication was prescribed  
Medication name \_\_\_\_\_  
How long taken \_\_\_\_\_

2. Has student ever had BCG vaccine?  
 No     Yes (year) \_\_\_\_\_  
*(persons who have received BCG vaccine are required to have a TB skin test)*

3. 2-step TB test: two Mantoux TB tests given one to three weeks apart  
#1 Date given \_\_\_\_\_ Date read \_\_\_\_\_ Result \_\_\_\_\_  
#2 Date given \_\_\_\_\_ Date read \_\_\_\_\_ Result \_\_\_\_\_

4. Chest x-ray, if necessary *(attach copy of report)*:  
Date \_\_\_\_\_ Result \_\_\_\_\_

5. Annual one-step TB testing (Parkland use only):  
Date given \_\_\_\_\_ Date read \_\_\_\_\_ Result \_\_\_\_\_  
Date given \_\_\_\_\_ Date read \_\_\_\_\_ Result \_\_\_\_\_  
Date given \_\_\_\_\_ Date read \_\_\_\_\_ Result \_\_\_\_\_  
Date given \_\_\_\_\_ Date read \_\_\_\_\_ Result \_\_\_\_\_

**HEALTHCARE PROVIDER CPR — required for CMA, DT, DHG, MSG, NUR, OTA, RTT, SUR, and XRA programs**

Renewal date \_\_\_\_\_ Renewal date \_\_\_\_\_  
*(attach copy of CPR card)*

**HEALTHCARE PROVIDER VERIFYING INFORMATION FOR PART II.**

Name (print) \_\_\_\_\_ Signature \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_ Date \_\_\_\_\_

# PART III — Physical Exam

To be completed by physician or nurse practitioner performing exam.

Name (print)		
Height	Weight	
BP (L)	BP (R)	Pulse
Hearing acuity	Corrected vision (Snellen) R 20/                      L 20/	

## ABNORMALITIES

YES    NO

1. Head, ears, nose, or throat..... .....
2. Respiratory ..... .....
3. Cardiovascular ..... .....
  - Organic heart murmur..... .....
4. Gastrointestinal..... .....
5. Hernia ..... .....
6. Eyes..... .....
7. Genitourinary..... .....
  - Severe menstrual cramps..... .....
8. Musculoskeletal..... .....
9. Metabolic/endocrine ..... .....
10. Neuropsychiatric ..... .....
11. Neurological ..... .....
12. Skin..... .....

## RECOMMENDATIONS FOR PHYSICAL ACTIVITY:

History of back injury or back problems?     Yes     No

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Able to regularly lift 25% of body weight?     Yes     No

## ABNORMALITIES/RECOMMENDED TREATMENT:

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## DESCRIPTION OF STUDENT'S CHRONIC ILLNESSES OR CONDITIONS, IF ANY:

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## MEDICATION/DRUG USE:

1. Prescribed \_\_\_\_\_
  2. Over-the-counter \_\_\_\_\_
  3. Alcohol \_\_\_\_\_
- Tobacco \_\_\_\_\_
- Recreational Drugs \_\_\_\_\_

*Based upon my exam and knowledge of this patient, I believe s/he can perform the technical skills (as outlined on the front of this record) required to be successful in this program.*

Yes     No

If no, please explain \_\_\_\_\_

Physician's name (print) \_\_\_\_\_ Date \_\_\_\_\_

Physician's signature \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

## RETURN COMPLETED FORM TO:

Wellness Coordinator, Parkland College, Room L234, 2400 West Bradley Avenue, Champaign Illinois 61821-1899