Owens Community College
Dental Hygiene Department
Student History and Physical Examination

To be completed by the student

Name: _____
Last First Middle

OCID Number: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email Address: _____

Course of Study (please circle): Dental Hygiene Dental Assisting EFDA

To be completed by health care provider.

History

Past Medical History:

Does the student have an allergy to latex?

☐ No
☐ Yes - Please specify the nature of the allergy: _____
_____

Attach associated laboratory testing and provide clinical recommendations for the student.

Does the student have any allergies to medications, food, environmental substances or other?

☐ No
☐ Yes - List: _____
_____

Is the student subject to classroom emergency?

☐ No
☐ Yes - Please explain: _____
_____

Name: _____ **OCID:** _____

IMMUNIZATION RECORD

Measles/Mumps/Rubella: Obtain titer (IGG). Even if have history of.

*Mumps IGG Date:	_____	Attach lab result
Rubeola IGG Date:	_____	Attach lab result
Rubella IGG Date:	_____	Attach lab result

NOTE: if either result is equivocal or negative, determine if vaccination is necessary and document.

Varicella: Obtain titer (IGG). Even if have history of. Immunize if negative and not contraindicated.

VZV IGG Date:		_____	Attach lab result
Varicella Vaccination	#1:	_____	
	#2:	_____	(4-8 weeks later)

Hepatitis B: Obtain antigen (HBsAg). Immunize * if negative OR If 3 dose vaccine series completed, obtain antibody (HBsAb).

HBsAg Date: Antigen		_____	(Before beginning injections)
Hepatitis B Vaccination Series:			
	#1	_____	
	#2	_____	(1 month later)
	#3	_____	(5 months later)
HBsAb Date: Antibody		_____	(3 months later)

Attach lab results

Note: If equivocal or negative, determine if booster(s) are necessary and document. A current HBsAg is also required.

*If individual refuses immunization, a declination (waiver) form must be completed and a yearly HBsAg must be submitted to the Dental Hygiene Department. Declination forms are available in the Dental Hygiene Department.

Tetanus or T-Dap Immunize: if last dose was administered more than 10 years ago.

Date: _____

Name: _____ **OCID:** _____

Name: _____ **OCID** _____

Tuberculosis: 2 step first year, then 1 step yearly. Note: Tine test is NOT accepted.

Step 1	**Step 2** (7 – 60 days after Step 1)
PPD .01 ml ID	PPD 0.1 ml ID
READ IN 48-72 HOURS	READ IN 48-72 HOURS
Date administered: _____	Date administered: _____
Date read: _____	Date read: _____
Results: _____	Results: _____

Chest X-ray required if Mantoux is positive, yearly for three years after first converting to positive.

CXR date: _____ **Attach copy of interpretation**

Absence of active disease: ☐ Yes
☐ No – explain _____

Physical Examination

Height_____ Weight_____
Temperature_____ Pulse_____
Respiration_____ Blood Pressure_____
Eyes_____ WNL Except:_____
Hearing_____ WNL Except:_____
General Appearance_____ WNL Except:_____
Skin _____ WNL Except:_____
HEENT _____ WNL Except:_____
Respiratory _____ WNL Except:_____
Cardiovascular _____ WNL Except:_____
Neurological _____ WNL Except:_____
Musculo-Skeletal_____ WNL Except:_____
Abdomen_____ WNL Except:_____

Is this individual fit for duty and free of communicable disease? ☐ Yes ☐ No*
*If no, please explain: _____

After this examination, do you believe that this person's health history, physical and mental health findings justify his/her undertaking the Nursing Program, including clinical experience with direct patient contact in health care agencies? ☐ Yes ☐ No*
*If no, please explain: _____

_____ _____

Signature (MD or DO or NP) **Date**

Address Stamp (REQUIRED):