OWENS COMMUNITY COLLEGE
DENTAL HYGIENE PROGRAM
P.O. BOX 10,000 OREGON ROAD
TOLEDO, OH 43699-1947

PHYSICIAN'S REPORT
PHYSICAL EXAMINATION

TO THE PHYSICIAN: Please complete the examination, sign this report, and return to the College at the address listed above. The following tests are required for admission to the program: Rubella titre, T.B. Skin test, CBC, Urinalysis, Mumps Titer and VDRL.

TO BE COMPLETED BY STUDENT

Name: _____
Last First Middle

Social Security Number: _____ Date of Birth: _____

Address: _____
Street

_____
City State Zip Code

Telephone: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

History

I. History: Provide summary of significant symptoms and illnesses from complete history.

Does the student have an allergy to latex?

- ☐ No
- ☐ Yes Please specify a clinical recommendation for the student. _____

_____

Does the student have an allergies to medications, food, environment substances or other?

- ☐ No
- ☐ Yes List _____

_____

Is the student subject to classroom emergency?

- ☐ No
- ☐ Yes Please explain: _____

_____

Does the student have a history of rheumatic heart disease?

Yes _____ No _____

Does the student require prophylactic premedication for dental treatment?

Yes _____ No _____

If yes, please explain. _____
_____

LAB WORK REQUIRED

1. CBC _____
   Date
2. Urinalysis _____
   Date
3. VDRL _____
   Date
4. Mumps Titer _____
   Date
5. Rubella Titre – unless documentation of MMR Vaccination.

6. Flu Vaccination _____
   Date

*****The lab test results must be attached to this form or sent separately to the Dental Programs Office at Owens Community College.*****

Immunization Record

Attach lab results and/or vaccination record.

Measles/Mumps/Rubella

If 2 documented doses, titers not necessary. If unable to document 2 doses, titers (IGG) ***REQUIRED.***

*Mumps IGG Date: _____ *Attach lab result*
***** MUST HAVE MUMPS IGG DRAWN EVEN IF HAD 2 MMRS OR THE DISEASE****
MMR #1_____ MMR #2_____

- Attach vaccination record -
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.

Hepatitis B

*Obtain antigen (HbsAg). Immunize * if negative OR If 3 dose vaccine series completed, do antibody (HbsAb).*

HbsAg Date _____ Result _____
Hepatitis B vaccination series
#1 _____
#2 _____ (1 month later)
#3 _____ (5 months later)

HbsAb Date _____ Result _____

Note: If equivocal or negative, determine if booster(s) necessary and document

*If individual refuses immunization a declination (waiver) form must be completed and a yearly HbsAg must be submitted to the Dental Department.

Tetanus
Immunize if last dose was administered more than 10 years ago

Date _____

Diphtheria Toxoid *(Immunize, etc)*

Date _____

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

Step 1	Step 2
PPD 0.1 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 _____

Results must be documented by Physician's Office.

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

CXR date _____
Absence of active disease □ Yes
□ No Please explain:

Flu Vaccination
Flu Vaccination within past 12 months (Oct-Mar) Date: _____

Physical Examination

Height		Weight	
Temperature		Pulse	
Respiration		Blood Pressure	
Eyes (include Snellen)	OD	OS	OU
Hearing	AD	AS	AU
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 Dental Hygiene Program, including clinical experience with direct patient.

□ Yes □ No Please explain:

_____ _____

Signature (MD or OD ONLY) Date

Address Stamp:

Eye Exam

After the examination it is determined that the person must use corrective lenses.

□ Yes □ No

_____ _____

Signature (MD or OD ONLY) Date

Address Stamp:

The person requires vision correction to render dental treatment and has acquired the appropriate correction.

□ Yes □ No

_____ _____

Signature (MD or OD ONLY) Date

Address Stamp:

Health Requirements Checklist

The lab test results must be attached to this form or sent separately to the Dental Programs Office at Owens Community College.

_____ 1. **Pre-medication required for dental treatment (yes or no).**

_____ 2. **CBC**

_____ 3. **Urinalysis**

_____ 4. **RPR/VDRL**

_____ 5. **Mumps Titer**

_____ 6. ****2-Step PPD**

_____ 1st

_____ 2nd

_____ 7. **Diphtheria Toxoid & Tetanus Toxoid**

_____ 8. **MMR**

_____ 9. **Rubella Titre – unless documentation of MMR Vaccination**

_____ 10. **Flu Vaccination**

_____ 11. **Hepatitis B Documentation**

_____ 1st

_____ 2nd

_____ 3rd

_____ 12. **Physical form completed.**

_____ 13. **Eye Exam**