Student Name: _____ M00#:_____

Monroe Community College
STATE UNIVERSITY OF NEW YORK

HEALTH SERVICES DEPARTMENT
HEALTH HISTORY & PHYSICAL EXAM FORM
DENTAL HYGIENE/ASSISTING PROGRAM

1. **Purpose:**
   - Completion of this health packet is mandatory prior to clinical participation to ensure the health and safety of both students and patients. The information you provide will be evaluated against the technical standards that have been validated as essential for participation in the program.

2. **For Students:**
   - Please complete Section 1 and 2 of this packet in ink. Your name and student ID number (M00 #) must be on each page in case the pages become separated.
   - Completion of this entire packet (including vaccines or waivers, tuberculosis screening and proof of a physical exam done within the past year) is required from each student before submission.
   - Please monitor your MCC student email account, as an RN will review your health packet and contact you via student email to let you know if anything else is needed. This process can take up to 72 hours.

3. **For Healthcare Providers**:
   - Please ensure that the PPD and all of the immunization requirements on page 5 have been met.
   - ***An EMR form documenting a physical exam done in the past year is acceptable, however the final four questions on our physical form must be completed and signed by the provider. This is a NYS Department of Health requirement for students entering a health career program.***

Student Name: _____ M00#:_____

STUDENT TO COMPLETE PAGES 1-3

1. **DEMOGRAPHICS**
   - Today's Date: _____ Date of Birth: _____
   - Cell Phone #: _____ Home phone: _____
   - Emergency Contact: _____ Phone: _____
   - Name/phone of primary doctor: _____
   - Health Insurance Carrier: _____ ID number: _____
   - CPR Card Expiration Date: _____ Organization Card Originated From: _____

2. **ALLERGIES** - **Please list all allergies (such as to drugs, bees, latex etc.**
   - Substance: _____Reaction_____Treatment:_____
   - Substance: _____Reaction_____Treatment:_____
   - Substance: _____Reaction_____Treatment:_____
   - Substance: _____Reaction_____Treatment:_____

3. **MEDICINES: Please list all you use, including over the counter medications.**
   - Medicine: _____Dose:_____ Times/Day: _____Used for: _____
   - Medicine: _____Dose:_____ Times/Day: _____Used for: _____
   - Medicine: _____Dose:_____ Times/Day: _____Used for: _____
   - Medicine: _____Dose:_____ Times/Day: _____Used for: _____

4. **CONFIDENTIAL HEALTH HISTORY: Mark each that apply, add details or more information below**
   - _____ADD/ADHD (circle one) _____Anxiety or Panic Attacks _____Asthma
   - _____Back problems _____Colitis _____Concussions/ Head injuries _____Depression
   - _____Eating disorder _____Type 1 Diabetes _____Type 2 Diabetes
   - _____Hearing impaired/deaf _____Heart problems _____High blood pressure
   - _____History of fainting _____Migraines _____Neurological issue _____
   - _____Seizures: petit/focal/grand (circle) Last Seizure_____
   - _____Severe menstrual cramps _____ Thyroid issues
   - _____Tuberculosis _____Uncorrected vision problem

   - More information: _____
   - Hospitalizations: _____
   - Surgeries: _____

5. **I attest to the truthfulness of the above statements and that I am free from habituation or addiction to depressants, stimulants, narcotics and other behavior altering substances.**

Student Signature: _____**Date:** _____

Student name: _____ M00_____

STUDENT CHECKLIST FOR TECHNICAL STANDARDS
FOR THE DENTAL HYGIENE/ASSISTING PROGRAM*

(Please circle responses as appropriate).

1. Able to reach, move and adjust x-ray tube located at a height of approximately 54 inches from the floor. **Yes No Not Known**

2. Able to reach into darkroom tanks for processing located at a height of 36-40 inches. **Yes No Not Known**

3. Can give clear verbal commands to the patient while performing dental hygiene services, and at a distance of 6-10 feet from the x-ray chair while located behind a lead protected exposure control wall. **Yes No Not Known**

4. Have hearing corrected to be able to hear a patient at a distance of 6-10 feet while located behind a lead protected exposure control wall. **Yes No Not Known**

5. Have sight corrected to read millimeter markings at a distance of 8-12 inches. **Yes No Not Known**

6. Able to operate rheostat control with feet. **Yes No Not Known**

7. Have use of hands and fingers and adequate range of motion to safely perform all necessary instrumentation in providing preventative dental hygiene services. **Yes No Not Known**

8. Able to sit on operator's stool on a seat approximately 19 inches from the floor. **Yes No Not Known**

9. Have arms proportionately long enough to fit across own body and reach head and neck area of patient. **Yes No Not Known**

10. Currently **not** using illegal drugs. **Yes No Not Known**

11. Not allergic to film processing chemicals (developer and fixer solutions) or personal protective gloves, masks, and eyewear used for "universal precautions". **Yes No Not Known**

12. If "no" or "not known" is circled, please comment on the space provided below.

13. _____
_____
_____
_____
_____

14. Student Signature: _____Date: _____

[1] *Adapted from Fritsma, G.A., B.J. Fiorella, and M. Murphy. Essential Requirements for Clinical Laboratory Science. Clin. Lab. Sci. 9(1):40-3. 1996.

Student name: _____ M00_____

- **MENINGITIS VACCINE REQUIREMENT-YOU MUST CHOOSE ONE OPTION:**

1. Provide Proof of a Meningitis ACWY Vaccine received IN THE PAST 5 YEARS on page 5.
   (If you are not sure if you received this vaccine, or if it was over 5 years ago, decline below for now)

OR

1. Decline the vaccine by signing below attesting that: I have reviewed the information regarding meningococcal disease available at health.ny.gov/publications/2168, in print in the health office, or at Health Services webpage under Immunizations. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal disease. I understand this does not prevent me from receiving the vaccine in the future, from my private health care provider, local health department or the Monroe County Health Department's Immunization Clinic at 111 Westfall Rd, Rochester, NY 14620. Phone 585-753-5150.

Student Signature (or parent if under 18):_____ Date:_____

- **HEPATITIS B VACCINE REQUIREMENT-YOU MUST CHOOSE ONE OPTION**
- Provide proof of the Hepatitis B vaccine series on page 5 or a positive immune titer OR

- Decline the Vaccine (y*ou are not required to receive the vaccine)* by signing below:

I understand that due to my possible exposure to blood or body fluids in my training, I may be at risk of acquiring Hepatitis B virus infection, a serious liver disease. I decline the vaccine at this time. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I wish to be vaccinated with the Hepatitis B vaccine, I can receive this vaccine from my physician or from the health care agency that employs me.

STUDENT SIGNATURE (or parent if under 18): _____
DATE:_____

Student name: _____ M00_____

PROVIDER COMPLETE THIS SECTION

TUBERCULOSIS REQUIREMENT FOR ALL STUDENTS

Student must show proof of one of the following:

1. **Tuberculin Skin Test Within Past Year:** Date Placed: _____ Date Read: _____
   Result in mm: _____ Result is: Positive or Negative

2. **IGRA Blood Test Within Past Year:** Date: _____Result: Positive or Negative

3. **For Those With A New Positive TB Test Or Known Past Positive**:
   - Student Must Show Proof of A Negative Chest X-Ray Completed At Any Time After the + Test.

     Date of Positive Test: _____Date of Chest X-Ray:_____
     Please circle one for Chest x-ray result: Normal Or Abnormal
     Treatment or Referral: _____

   - Check Off Any Symptoms Shown In Past Year (Check All That Apply)

     None____ Night Sweats_____ Unexplained Weight Loss _____Cough for 3 Weeks_____ Unexplained Fever_____ Bloody Sputum _____ Unexplained Fatigue_____

Signature of HealthCare Provider: _____ **Date:** _____

IMMUNIZATION REQUIREMENTS FOR ALL STUDENTS

1. **Proof Of Immunity To Measles, Mumps And Rubella By One Of The Following:**

   - Two MMR Vaccines #1_____ #2_____ OR
   - Positive IgG Immune Titers: (Attach Test Results Or Enter Dates Below):
     Rubeola titer: _____ Rubella titer: _____ Mumps titer: _____

2. **Proof Of Immunity To Varicella By One Of The Following:**

   - Two Varicella (Chicken Pox) Vaccines: #1: _____ #2: _____
   - Date of Positive Varicella titer: _____ (or you may attach lab results)
   - Date of Varicella Disease Diagnosed by Provider: _____
   - Date of Herpes Zoster (Shingles) Diagnosed by Provider:_____

3. **Tetanus Booster in Past 10 Years** Date: _____ Circle One: Tdap Or Td

4. **Proof Of Immunity To Hepatitis By One of the Following (Or Student May Sign The Declination On Page 3)**
   - Date of Doses: #1:_____ #2:_____ #3:_____
   - Date of positive Hepatitis B Surface Antibody Titer: _____ (or attach lab results)
   - If student is in process in the series, student should sign the declination and send in vaccine dates as received)

5. **Meningitis ACWY Vaccine (Within 5 Years) (Or Student May Sign The Declination On Page 3)**
   Date: _____

6. **Date of Influenza Vaccine For Current Season:** _____

Student name: _____ M00_____

(To Be Completed By Health Care Provider. An EMR Generated Sports Physical May Be Substituted

1. Allergies: _____

2. Medications & Supplements: None or

_____

_____

3. Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____

4. Uncorrected Vision: R ____/____ L ____/____ Corrected Vision: R ____/____ L ____/____

5. Date of Exam (Must Be Within One Year): _____/_____/_____

Area Examined	Check Below if Normal	Describe Abnormal Findings
Hand/Skin	_____	_____
Head/Eyes	_____	_____
Ears/Nose/Throat/Mouth	_____	_____
Neck/Nodes	_____	_____
Chest/Lungs	_____	_____
Cardiovascular	_____	_____
• Carotid Arteries	_____	_____
• Neck Veins	_____	_____
• Apical Pulse	_____	_____
• Heart Sounds	_____	_____
Abdomen	_____	_____
Musculoskeletal/Extremity	_____	_____
Musculoskeletal/Spine	_____	_____
Nervous System	_____	_____
Genitourinary	_____	_____

PHYSICIAN OR HEALTH CARE PROVIDER, carefully read the following statement, and check the appropriate boxes.

1. Are there musculoskeletal restrictions related to mobility, range of motion, lifting, or manual dexterity? Yes No If yes, please explain: _____

_____

2. Are there uncorrected hearing restrictions which would impair the student from hearing audible alarms or engaging in telephone or oral communication with patients? Yes No If yes, please explain:_____

_____

3. Are there uncorrected sight restrictions which would impair the student from accurately reading gauges and calibrated equipment? Yes No If yes, please explain: _____

_____

I performed the above medical evaluation and found to the best of my knowledge, him/her to be free from physical or mental impairments, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior-altering substances which might interfere with the performance of his/her duties or would pose a potential risk to patients or personnel.

YES NO If NO is checked, please identify those problems which might interfere with the performance of his/her duties or would pose a potential risk to patients or personnel. _____

_____

_____

_____

PHYSICIAN'S/HEALTH CARE PROVIDER (WITH TITLE) SIGNATURE **PRINT PHYSICIAN'S/HEALTH CARE PROVIDER LAST NAME/STAMP**

_____

PHYSICIAN'S ADDRESS **PHYSICIAN'S TELEPHONE NUMBEROFFICE FAX # (IF APPLICABLE)**

RETURN TO: MONROE COMMUNITY COLLEGE **1000 EAST HENRIETTA RD.** **PHONE: 585-292-2018, FAX 585-293856**

HEALTH SERVICES DEPARTMENT **ROCHESTER, NY 14623-5780**