Student Name_____ M00#_____

Health Services
MONROE COMMUNITY COLLEGE

Health Services Department
Dental Hygiene / Assisting Program

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.

Students

- Please complete Section 1, 2 and 3 of this career packet. Your name and student ID number (M00 #) must be on each page in case the pages become separated. These are fillable PDF forms. You can use your computer to fill in the student fields and then print it out to sign and date using ink or the forms can be completed in ink.
- 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.

Healthcare Providers

- Please ensure that the PPD and all of the immunization requirements Section 4 have been met.
- Be sure the four questions on the top of the physical form are completed and signed by the provider. This is a NYS Department of Health requirement for students entering a health career program.

Health Services
MONROE COMMUNITY COLLEGE

COVID-19 Screening Form

Last Name: _____ First Name: _____ MI: _____

M#: _____ Date of Birth: _____ Age: _____

Cell Phone: _____ Email: _____

Gender: ☐ Male ☐ Female ☐ Student ☐ Employee

Please complete this form to assess your potential exposure / possession of COVID-19 and other illnesses.

Are you currently free from illness? ◯ Yes ◯ No

Do you have: heart disease ◯ Yes ◯ No

lung disease ◯ Yes ◯ No

kidney disease ◯ Yes ◯ No

diabetes ◯ Yes ◯ No

autoimmune disease ◯ Yes ◯ No

During your time away from Monroe Community College, did you experience, or are you currently experiencing any of the following:

Symptoms: *Check all that apply*

☐ Fever ☐ Loss of Smell ☐ Diarrhea ☐ Body Chills ☐ Sore Throat

☐ Upset stomach ☐ Extreme Level of Fatigue ☐ Loss of Taste ☐ Cough

☐ Body / Muscle Aches ☐ Pain/Difficulty Breathing ☐ Shortness of Breath

- 2-14 days prior to experiencing these symptoms, did you experience a suspected exposure to COVID-19?
  ◯ Yes ◯ No
- Have you had any direct contact with anyone who lives in or has visited a place where COVID-19 is spreading and/or is an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?
  ◯ Yes ◯ No
- Have you had any direct contact with someone that has a suspected or lab confirmed case of COVID-19?
  ◯ Yes ◯ No
- During your time away from INSTITUTION, did you self-quarantine due to suspected symptoms or exposure of COVID-19?
  ◯ Yes ◯ No
- During your time away from INSTITUTION, have you been living in, or have visited an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?
  ◯ Yes ◯ No

- Have you previously been or are you currently diagnosed with COVID-19?

  ◯ Yes ◯ No Date of Diagnosis: _____

Do you have medical documentation to support your diagnosis and treatment of COVID-19?

◯ Yes ◯ No

Physician Name: Phone: _____

Physician Address: _____

Please list any countries/states/cities you have traveled to since March 15th, 2020 and the dates you were there:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____
4. _____ Dates: _____
5. _____ Dates: _____

COVID Vaccine

Date 1st dose:_____ Product Name/Manufacturer:_____

Date 2nd dose:_____ Product Name/Manufacturer:_____

Signature: _____Date_____

Student Name_____ M00#_____

Health Services
MONROE COMMUNITY COLLEGE

Section 1

Dental Hygiene / Assisting Health History Form

Student to Complete

Demographics

Today's Date: Date of Birth:

Student Address:

Cell Phone #: Home Phone #:

Emergency Contact: Phone:

Primary Doctor Name: Primary Doctor Phone:

Health Insurance Carrier: ID Number:

Allergies

Please list all allergies (such as to drugs, bees, latex, etc.)

Substance:	Reaction:	Treatment:
Substance:	Reaction:	Treatment:
Substance:	Reaction:	Treatment:
Substance:	Reaction:	Treatment:

Medicines

Please list all you use, including over the counter medicines

Medicine:	Dose:	Times/Day:	Used For:
Medicine:	Dose:	Times/Day:	Used For:
Medicine:	Dose:	Times/Day:	Used For:
Medicine:	Dose:	Times/Day:	Used For:

Confidential Health History

Mark each that apply, add details or more information below.

☐ ADD ☐ ADHD ☐ Anxiety or Panic Attacks ☐ Asthma ☐ Back Problems
☐ Colitis ☐ Concussions/Head Injuries ☐ Depression ☐ Eating Disorder
☐ Type 1 Diabetes ☐ Type2 Diabetes ☐ Hearing Impaired/Deaf ☐ Heart Problems
☐ High Blood Pressure ☐ History of Fainting ☐ Migraines ☐ Neurological Issue
☐ Severe Menstrual Cramps ☐ Thyroid Issues ☐ Tuberculosis ☐ Uncorrected Vision Problem
☐ Seizures: ☐ Petit ☐ Focal ☐ Grand Last Seizure:_____

More Information:

Hospitalizations:

Surgeries:

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#_____

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Section 2
Student Checklist for Technical Standards

Student to Complete

1. Able to reach, move and adjust x-ray tube located at a height of approximately 54 inches from the floor.
   ☐ Yes ☐ No
2. Able to reach into darkroom tanks for processing located at a height of 36-40 inches.
   ☐ Yes ☐ No
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
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
5. Have sight corrected to read millimeter markings at a distance of 8-12 inches.
   ☐ Yes ☐ No
6. Able to operate rheostat control with feet.
   ☐ Yes ☐ No
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
8. Able to sit on operator's stool on a seat approximately 19 inches from the floor.
   ☐ Yes ☐ No
9. Have arms proportionately long enough to fit across own body and reach head and neck area of patient.
   ☐ Yes ☐ No
10. Are you using illegal drugs?
    ☐ Yes ☐ No
11. Are you allergic to film processing chemicals (developer and fixer solutions) or personal protective gloves, masks, and eyewear used for "universal precautions".
    ☐ Yes ☐ No
12. If "no" is checked, please comment on the space provided below.

_____

_____

_____

_____

Student Signature:_____ Date:_____

Student Name_____ M00#_____

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Section 3
Vaccine Requirements

Meningitis

You must choose one option.

1. Provide Proof of a Meningitis ACWY Vaccine received in the past 5 years that is in Section 4, #5. (If you are not sure if you received this vaccine, or if it was over 5 years ago, decline below for now)

OR

2. 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, (585) 753-5150.

Student Signature (parent if under 18):_____

Date:_____

Hepatitis B

You must choose one option.

1. Provide proof of the Hepatitis B vaccine series that is in Section 4, #4 or a positive immune titer

OR

2. Decline the Vaccine by signing below: (*you are not required to receive the vaccine)*

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 (parent if under 18):_____

Date:_____

Student Name_____ M00#_____

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Section 4
Tuberculosis & Required Immunizations

Provider to complete this section.

Tuberculosis

Student must show proof of one of the following:

- ☐ Tuberculin Skin Test within past year: Date placed_____ Date read_____
  Result in mm:_____ Result is:____Positive_____Negative
- ☐ IGRA Blood Test within past year: Date_____ Result is:____Positive_____Negative
- ☐ For those with a new positive TB Test or Known Past Positive:
  - Student must show proof of Negative Chest X-Ray completed at any time after the + test.
    Date of Positive Test:_____Date of Chest X-Ray:_____
    Chest x-ray result:____Normal____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 Health Care 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 in Section 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 in Section 3)
   - Date:_____
6. Date of Influenza Vaccine for Current Season:_____

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Section 5
Dental Physical Exam

Student Name:_____DOB:_____M00#: _____

To Be Completed by Health Care Provider.

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. _____

_____

_____

Allergies:_____

Medications & Supplements: None or_____

_____

Height:_____Weight:_____Blood Pressure: _____/_____Pulse:_____

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	_____	_____

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

Health Care Provider's Signature or Stamp (With Title): _____

Print Health Care Provider's Last Name: _____

HCP's Address: _____

Office Phone #:_____Office Fax #:_____

Return to: Monroe Community College - Health Services Department, 1000 East Henrietta Road, Rochester, NY 14623
(585) 292-2018 Fax (585) 292-3856