

**IMPORTANT DEADLINE #1:**

Immunizations and physical examinations should be initiated by July 6, 2009 to allow sufficient time to process forms. *The physical examination should not be completed more than 6 months prior to the month of entry.*



The Health and Immunizations Form must be returned by Aug 20, 2009 and accepted as "complete for entry" by the Health Sciences nurse evaluator for the student to matriculate during the Fall 2009 semester.

## Health Sciences and Nursing Programs -- Student Health Form

Applicant for: ( X ) Fall ( ) Spring ( ) Summer Semester Year: 2009 Program Dental Hygiene

**DIRECTIONS:** Please **print** in ink or **type** Section I (two pages) before going to your physician for examination. Be sure to answer **ALL** questions fully and put your name on all 5 pages .

### SECTION I (By Student)

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Home Address: \_\_\_\_\_  
(Number and Street) (City) (State) (Zip) (College E-mail Address)

\_\_\_\_\_  
Student College ID (Not Social Security Number) ( ) - Home Phone Number ( ) - Cell or Business Number / / Birthday

### IN CASE OF EMERGENCY NOTIFY

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
(Number and Street) (City) (State) (Zip Code)

Telephone: \_\_\_\_\_  
(Home) (Cell or Business)

### A: PAST MEDICAL HISTORY

Check "Yes or No" for each box below. On the next page give dates and treatments on ALL "YES" answers.

HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO
Rubeola (Red Measles)			Diabetes		
Rubella (German Measles)			Kidney/Bladder Abnormality		
Mumps			Heart Disease/Heart Murmurs		
Chicken Pox			Arthritis		
Rheumatic Fever			Stomach/Intestinal Abnormality		
Infectious Mono			Hay Fever		
Hepatitis			Allergies to Environment, Medications, Foods, Latex, etc.		
Asthma			Color Blindness		
Positive T.B. Skin Test			Recurrent Headaches		
Mental/Emotional Disorders			Back Problems		
Frequent Dizziness			High Blood Pressure		
Epilepsy/Convulsions			Organ Transplants		
Other			Implants		

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STUDENT'S NAME \_\_\_\_\_  
 (Last) (First) (Middle)

**B: DIAGNOSIS**

If you answered, "YES" to any question in Section I A on the first page, complete the following:

DATE	DIAGNOSIS (use list from previous page)	TREATMENT

**C: SURGERIES**

DATE	TYPE OF SURGERY

**D: CURRENT MEDICATIONS**

MEDICATIONS
1) _____
2) _____
3) _____
4) _____

**E: RESTRICTIONS**

Has your ability to perform "essential functions required for this program" noted on page 4 been restricted or limited during the past three years? ( ) YES ( ) NO If yes, give reasons and duration. \_\_\_\_\_

**I hereby certify to the best of my knowledge that the preceding information is complete and accurate.**

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

\_\_\_\_\_  
 Date

**NOTE:** The **student** is responsible for ensuring completeness of the Health Form: acquiring all signatures and all attachments; ensuring their Physician/Physician Assistant/Nurse Practitioner fills in all spaces on the physical exam section; ensuring the immunization page is complete and that all blocks signed.

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**SECTION II: HEALTH ASSESSMENT (by Physician, Physician Assistant or Nurse Practitioner)**

**Directions to the Physician/Physician Assistant/Nurse Practitioner:**

After reviewing the student's **Past Medical History** (see previous 2 pages), please complete pages 3 and 4. Both pages should be signed and dated.

STUDENT'S NAME \_\_\_\_\_  
 (Last) (First) (Middle)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Does the student have any **abnormalities** in the following systems? (Give dates, description for abnormality and treatment on all **positive** findings.) Check **all** systems "YES" or "NO".

**A: SYSTEMS**

SYSTEM	ABNORMALITIES?		COMMENTS/DIAGNOSIS/TREATMENT
	YES	NO	
Eyes			Corrected Vision Right 20/___ Left 20/_____
Ears			Hearing : Right ( ) Normal ( ) Impaired Left ( ) Normal ( ) Impaired
Nose, Throat			
Neurological			
Respiratory			
Cardiovascular			
Gastrointestinal			
Musculoskeletal			
Metabolic/Endocrine			
Genitourinary			
Skin			
Immunological			
Psychiatric			

\_\_\_\_\_  
 Physician's/Physician Assistant's/Nurse Practitioner's Name (print)

\_\_\_\_\_  
 Telephone Number

\_\_\_\_\_  
 Physician's/Physician Assistant's/Nurse Practitioner's Signature  
 Revised Spring 2009

\_\_\_\_\_  
 Date

STUDENT'S NAME \_\_\_\_\_

(Last)

(First)

(Middle)

**B: ESSENTIAL FUNCTIONS NECESSARY FOR THE DENTAL HYGIENE PROGRAM**

Applicants and students should be able to perform essential functions, or with reasonable accommodations (such as with the help of compensatory techniques and/or assistive devices), be able to demonstrate ability to be proficient in these essential functions. Based on the health assessment which you performed, please indicate whether you noted conditions which might limit the student's ability to perform the essential functions, or for which they will need reasonable accommodation to perform the functions:

Essential Function	Technical Standard	Examples of Necessary Activities (Not all inclusive)	Limitations		Accommodations Needed (Please list)
			Yes	No	
<b>Critical Thinking</b>	Critical thinking ability sufficient for clinical judgment	Identify cause-effect relationships in clinical situations; evaluate patient or instrument responses; synthesize data; draw sound conclusions.			
<b>Interpersonal</b>	Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural and intellectual backgrounds.	Establish rapport with patients and colleagues. Use therapeutic communication (attending, clarifying, coaching, facilitating, and teaching. Function (consult, negotiate, share) as a part of a team.			
<b>Communication Ability</b>	Communication abilities sufficient for effective interaction with others. in spoken and written <b>English</b>	Explain treatment procedures; initiate health teaching; document and interpret instructions. Listen attentively.			
<b>Physical Endurance</b>	Remain continuously on task for several hours while standing, sitting, moving, lifting and/or bending. Must lift 30 lbs.	Manually resuscitate patients in emergency situations or stand/walk for extended periods of time.			
<b>Mobility</b>	Physical abilities sufficient to move from room to room and maneuver in small spaces; full range of motion; manual and finger dexterity; and hand-eye coordination.	Move around in work area and treatment areas.			
<b>Motor Skills</b>	Gross and fine motor skills sufficient to provide safe patient care and operate equipment.	Use equipment and instruments with necessary dexterity.			
<b>Hearing Ability</b>	Auditory ability sufficient to monitor and assess health needs.	Ability to hear alarms, emergency signals, auscultatory sounds and cries for help.			
<b>Visual Ability</b>	Normal or corrected visual ability sufficient for patient observation and assessment, ability to discriminate between subtle changes in density (black and grey) or a color at low light.	Observe patient responses, secretions, and color. Read thermometer, chart, computer screen, digital printouts, labels and gauges.			
<b>Tactile Ability</b>	Tactile ability sufficient for physical assessment.	Perform palpation, functions of physical examination and/or those related to therapeutic intervention.			
<b>Olfactory Ability</b>	Olfactory senses (smell) sufficient for maintaining environmental and patient safety.	Distinguish smells, which are contributory to assessing and/or maintaining the patient's health status or environmental safety.			
<b>Professional Attitude and Demeanor</b>	Ability to present professional appearance and implement measures to maintain one's own physical and mental health and emotional stability,	Work under stressful conditions. Be exposed to communicable diseases and contaminated bodily fluids. React calmly in emergency situations. Demonstrate flexibility. Show concern for others.			

Physician's/Physician Assistant's/Nurse Practitioner's Name (print) \_\_\_\_\_

Telephone Number \_\_\_\_\_

Physician's/Physician Assistant's/Nurse Practitioner's Signature \_\_\_\_\_

Date \_\_\_\_\_

Revised Spring 2009

MANDATORY IMMUNIZATIONS/TESTS • Midlands Technical College, Health Sciences Program

STUDENT NAME: \_\_\_\_\_ Health Science Program Dental Hygiene

STUDENT ID # \_\_\_\_\_ Midlands Tech E-mail address \_\_\_\_\_

**This form must be filled out completely and each block signed by a Health Care Professional (Signature with Credentials).**

The following immunizations, tests or titers indicating immunity are **required** before entering any Health Sciences and Nursing Program.

Each immunization or titer **must** have specific date and state immunity (Pos. /Neg.).

**Health Professionals May Transfer Immunization /Test Dates From Other Legal Records and Sign This Form "Transferred by..."**

VACCINE	DATE OF IMMUNIZATION OR TITER State immunity (Pos. or Neg.)	HEALTH CARE PROFESSIONAL Signature with Credentials
1 TETANUS (Booster required every 10 years)	Date of vaccine: _____	Sign: _____
2 MMR Date of Vaccine →  2 Vaccines or DOB prior to 1957 Or Positive Titers for M, M, R Dose #1 – on or after 1 <sup>st</sup> . Birthday Dose #2 – 4 weeks after dose #1 or later  MMR titers are <b>required</b> if you cannot show Proof of 2 MMRs and cannot have the Vaccine and your DOB is after 1957.  If the titer is negative, you must complete the 2 vaccinations.	#1 _____ #2 _____ (date) (date) <b>OR</b> Date of Birth Before 1957 DOB _____ <b>OR</b> Mumps Titer Date: _____ Results: _Pos Neg Rubeola Titer Date: _____ Results: _Pos Neg Rubella Titer Date _____ Results: _Pos Neg	Sign: _____ <b>OR</b> Sign: _____ <b>OR</b> Sign: _____ Sign: _____ Sign: _____
You may be exempt from the MMR only if: (1) You are pregnant or trying to conceive. (2) You have a history of anaphylactic reaction to gelatin, neomycin, or eggs. If you cannot receive the MMR vaccine you will be <b>required</b> to attach a Physician's statement to your Health Form, and have titers for MMR done. <b>Students</b> born before 1957 are assumed to be protected through natural disease.		
3 VARICELLA (CHICKEN POX) A documented history of having chicken pox is not sufficient documentation for a person working in healthcare. A titer is required; if the titer is negative, then you must receive 2 vaccines, 4 weeks apart.	Varicella Titer Date: _____ Results: Pos Neg <b>A negative titer requires you to have the two vaccinations noted below</b> #1 _____ #2 _____ Date of Vaccine #1 Date of Vaccine #2	Sign: _____ <b>AND/NA</b> Sign: _____
If you cannot receive the Varicella vaccine you will be <b>required</b> to attach a Physician's statement to this Form. Varicella titer is required for all students.		
4 TB TEST (PPD) *2 Step PPD Skin Test (Mantoux Only) Step 1 → If Step 1 is negative – 1-3 weeks after Step 1 Give Step 2 (see below)  Step 2 → **Positive TB Skin Test (See Below) **BCG (See Below)	Date Given _____ Date Read _____ Result _____ <b>AND</b> Date Given _____ Date Read _____ Result _____	Sign: _____ Sign: _____ <b>AND</b> Sign: _____ Sign: _____
*Two-step testing is used to distinguish boosted reactions and reactions due to new infection. If the reaction to the first test is negative, a second test should be done 1 to 3 weeks later. Two-step testing should be used for the initial skin testing of adults who will be retested periodically, such as health care workers. If you have had a PPD within the year it may be used as the first step. <i>Core Curriculum On Tuberculosis, What the Clinician Should Know</i> , CDC, Third Edition, 1994, page 22, 23. **If TB Skin Test is <b>Positive</b> a copy of the results of a Chest X-Ray, within the last year, is required and <b>must</b> be attached to your Health Form. **Students that have had the BCG vaccination > 10 years ago <b>must</b> have the PPD skin test; however, those who have received BCG within the last 10 years should be individually assessed for the need for testing. <i>Infection Control and OSHA Essentials</i> ; Health Studies Institute, page 30. A Physician's statement <b>must</b> be attached to your Health Form regarding his/her assessment.		
5 Hepatitis B Series Dates of Vaccines →  <b>Titer required</b> (For both recently and formerly immunized) If titer is negative – you will need to have a booster and 4 weeks later have another titer.	#1 _____ Date #2 _____ Date #3 _____ Date <b>AND</b> Titer Date: _____ Result: POS NEG	Sign: _____ Sign: _____ Sign: _____ <b>AND</b> Sign: _____
Hepatitis B vaccine is mandatory for all Health Sciences students. Students who cannot take the vaccine must present a physician's statement. Four weeks after completion of the Hepatitis B Series, a titer will be <b>required</b> to check for immunity. <b>Hepatitis B Titers</b> are required for all students.		

**HS PROGRAM ACCEPTANCE REQUIRES THAT ALL ITEMS BE COMPLETED TO THE NURSE EVALUATOR'S STANDARDS BY Aug 20, 2009.**  
(MTC E-mail will be utilized for official communications.)