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**IMPORTANT**

Dear Applicant,

You are about to enter a health care field. For your own safety, and to comply with requirements for clinical rotations, it is imperative you have a physical examination, including drug testing and all immunizations and titers.

**Students have an option of either seeing their own physician for the medical exam or making an appointment with the Foothill College Student Health Services at (650) 949-7243.** At the student health center, physical exams, drug testing, and immunizations can be obtained at low cost. Some tests are free.

Please see that the following are completed:

1. **Applicant/student** completes the front page of the “Student Health Questionnaire Form”, “Authorization for Release of Drug Test Results” (page 2), and “Health Appraisal” (pages 3 & 4), and Technical Standards (page 5) forms. You **MUST TAKE THIS ENTIRE PACKET TO YOUR MEDICAL APPOINTMENT (pages 1-5).**
2. **Your physician or Foothill College Student Health Services** completes the medical exam and documents immunizations and updates vaccines when necessary. Make an appointment with the Foothill College Health Service for hearing, sight and drug testing.
3. **Copies** of all immunization and titer records must be attached and returned with these forms. If Hepatitis B doses are being started, please record the first dose. Record the dates the second and third dose on a prescription pad or office letterhead to give to program director final proof of immunization (since the completed exam form is turned in after the first Hep B injection. Health histories that do not indicate dates of immunizations or titer results will not be accepted.
4. **Make a copy** of all Health records for your personal file. Turn in the original documents to the program director.
5. The completed Health forms, immunizations, titers and drug testing must be completed by the

 first class meeting of DA 50 (Orientation to Dental Assisting) in September.

**FOOTHILL COLLEGE DENTAL ASSISTING PROGRAM**

**STUDENT HEALTH QUESTIONNAIRE FORM**

**AUTHORIZATION FOR RELEASE OF EXAM and LAB RESULTS**

**This Section To Be Completed By The Student**

Name (Print) Phone DOB

Address City Zip

Emergency Contact Info: Name Relationship: Phone:

Physician Info: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following questions regarding your health status. This information will facilitate the physician’s completion of the Health Appraisal form, as well as help insure the safety of the student and of patients. Students are not discriminated against due to physical limitation or diseases. Note: students may be required by the clinical facility to meet additional health requirements. The following information is confidential and does not affect entry into the program, unless you are unable to meet the Technical Standards.

|  |  |  |
| --- | --- | --- |
| 1. Do you have a hearing impairment?  | Yes No | \*If yes, please explain: |
| 2. Do you have a vision impairment? | Yes No | \*If yes, please explain: |
| 3. Do you have any condition that limits your physical mobility?  | Yes No | \*If yes, please explain: |
| 4. Do you have any condition that limits your ability to lift? | Yes No | \*If yes, please explain: |
| 5. Do you have allergies? | Yes No | \*If yes, please explain: |
| 6. Have you experienced fainting spells, dizziness, or convulsions | Yes No | \*If yes, please explain: |
| 7. Do you smoke? | Yes No | If yes, how much per day? |
| 8. Are you pregnant? | Yes No |  |
| 9. Are you taking any medication? | Yes No | \*If yes, please list medications and reason for taking. |
| 10. Please list any & all physical, medical, emotional, or psychological conditions you have. |  |  |

\*If you answered “yes” to any of the above questions and need more room, please attach numbered answers on a separate sheet of paper.

Do you have any concerns regarding your health in relation to performance in or completion of this program?

Areas of concern should be discussed with the director of the program prior to enrollment.

I have read the above carefully and have answered all questions correctly to the best of my knowledge. I hereby authorize Foothill College Health Services/Planned Parenthood Mar Monte (“Health Services”) to release and disclose all results of my physical, lab results, including lab printouts, and Drug Abuse Panel - 10-50 Plus Ethanol lab work (“drug tests”) to the Foothill College Dental Assisting Program (“Program”), **with full knowledge that my application to the program will be rejected if the drug tests reveal the presence of a controlled substance in my body.**

This authorization shall be valid until revoked in writing. The revocation will be effective on the date notified except to the extent that Foothill/PPMM has already acted upon the Authorization. My healthcare and payment for my healthcare will

not be affected if I do not sign this Authorization form. I have been offered a copy of this signed Authorization form.

**By signing this Authorization I hereby RELEASE FROM ALL LIABILITY both the Health Services and the Program for disclosing/acting upon said test results.**

**Date Student’s Signature**

**FOOTHILL COLLEGE DENTAL ASSISTING PROGRAM**

**HEALTH APPRAISAL FORM**

**Student’s Name: Student ID#: Date:**

**PLEASE NOTE: A COPY OF THIS STUDENT’S SIGNED TECHNICAL AND HEALTH STANDARDS ARE ATTACHED. PLEASE REVIEW BEFORE COMPLETING THE FOLLOWING FORM.**

**Height \_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_ Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BMI \_\_\_\_\_\_\_\_\_\_\_**

Check if Negative - otherwise please comment:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Nutrition |  |  | Teeth: Cavities |  |  |
| Posture |  |  |  Malocclusion |  |  |
| Skin |  |  | Tonsils |  |  |
| Nasal: Obs. |  |  | Heart |  |  |
|  Disch. |  |  | Lungs |  |  |
| Ears: Right |  |  | Abdomen |  |  |
|  Left |  |  | Ortho. |  |  |
| Eyes: Right |  |  | Hernia: Right |  |  |
|  Left |  |  |  Left |  |  |
| Lymph Glands |  |  | Neuro. |  |  |
| Extremities |  |  | Breasts |  |  |
| Back |  |  |  |  |  |
| Is there any impairment of vision or hearing for which the school could compensate by proper seating or other action? Yes No | If yes, what do you recommend? |
| Is there any physical impairment which may limit participation in: (a) Classroom activities Yes No(b) Clinical experience Yes No(c) Heavy lifting Yes No | If yes, what do you recommend? |
| Is this student subject to any of the following chronic conditions? i.e., epilepsy, fainting, diabetes, allergies, back injuries. Yes No  | If yes, what do you recommend? |
| Do you have knowledge of any emotional, mental or physical condition for which this student should remain under periodic medical observation? Yes No | If yes, what do you recommend? |

Does the above named individual exhibit any signs of active communicable diseases? If yes, please explain and include estimated

length of communicability and treatment modality.

COMMENTS:

**I have examined the above named individual and found no condition, which would present a hazard to him/herself, other employees, residents or visitors.**

**Physician/Clinician Signature Date**

**Physician/Clinician Name Phone**

 **Print/type**

Address City State Zip Code

**Student’s Name: Student ID#: Date:**

**THE FOLLOWING TESTS/IMMUNIZATIONS ARE REQUIRED BY ONE OR MORE OF THE CLINICAL SITES TO WHICH STUDENTS ARE ASSIGNED. A COPY OF THE FOLLOWING LABORATORY ISSUED RESULTS MUST BE SUBMITTED FOR THE FOLLOWING:**

**QuantiFERON TB TEST** **(serum)**

 Please attach lab results Date Titer Results:

 **OR**

 **2-STEP TB TEST:** Dates Administered: Dates Read: Results:

 **(Chest X-ray)** Date Taken: Result:

Is the student being put on anti-TB drug therapy? Yes No Refused Date of Treatment

**MUMPS TITER (serum)**

 Proof of immunity (6 weeks post immunization MMR)

 Please attach lab results Date Titer Results:

**RUBELLA (serum)**

 Current positive titer Date Titer Results

**RUBEOLA (serum)**

 Current positive titer Date Titer Results

**VARICELLA (serum)**

 Current positive titer Date Titer Results

**HEPATITIS B VACCINE** Date started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Vaccine must be started before clinical assignment)

**AND**

Hepatitis B Surface Antibody titer results Date: Results:

(6 wks post HBV immunization)

Hepatitis B Antigen (HBsAg) titer results Date: Results:

**CURRENT TDAP IMMUNIZATION OR BOOSTER** Date

Within the last 5 years

**CBC PANEL RESULTS:**

**URINE TEST RESULTS:**

**DRUG ABUSE PANEL**

10-50 Plus Ethanol Results: Positive Negative

**Audiogram Testing** (Free from College Health Service) Date: Results:

**Titmus eye exam** (Free from College Health Service) Date: Results:

I have examined the above named individual and found no condition which would present a hazard to him/herself, other employees, residents, or visitors.

Physician/Clinicians Signature Date

 Physician/Clinicians Name Phone

 Print/type

Address City State Zip

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**DENTAL ASSISTING PROGRAM**

**Technical / Health Standards and Physical Requirements**

#### To Health Care Provider For Your Information

# Please review the technical standards below required for Dental Assisting students:

The following statements identify the technical standards appropriate to the profession of Dental Assisting and students enrolled in the Dental Assisting Program.

A. Do you possess sufficient finger dexterity and eye/hand coordination to perform large and small motor coordination?

Yes No

B. Are you able to perform skills related to emergency procedures?

Yes No

C. Are you able to communicate both verbally and non-verbally in an effective manner to explain procedures and give instructions?

Yes No

D. Are you able to understand and react quickly to verbal instruction?

Yes No

E. Do you possess eyesight capable of viewing small visual images, and distinguish between black, white,

 and subtle shades of grey?

Yes No

F. At the end of the training program, the Dental Assistant must be able to:

 1. handle stressful situations related to technical and procedural standards

 of patient care situations, thus avoiding injury to the patients.

 2. provide physical and emotional support to the patient during procedures.

 3. follow directions effectively and work closely with members of the

 health care community.

 4. perform skills related to emergency procedures required in the field

**I have reviewed the technical standards with the Dental Assisting student.**

**Physician/Clinician Signature Date**