Prairie State College
Department of Dental Hygiene

PHYSICAL EXAMINATION

Name: ______________________________ Phone: (_____) ______________

Address: ______________________ City/State/Zip: ______________________

To The Applicant: ***Please have this form completed by a licensed physician***. Return duplicates of laboratory results and completed physical form to the Dental Hygiene prior to the beginning of summer classes.

PART I.

Vital Signs:

Temperature _____ Pulse _____ Respiration _____ Blood Pressure _____

Height _____ Weight _____

Record Findings, Indicating Normal and Abnormal

Normal	Abnormal		Normal	Abnormal	
☐	☐	Skin and Nails	☐	☐	Endocrine System
☐	☐	Head	☐	☐	Gastrointestinal System
☐	☐	Ears/Hearing	☐	☐	Pulmonary/Respiratory System
☐	☐	Nose and Sinuses	☐	☐	Genitourinary System
☐	☐	Mouth and Pharynx	☐	☐	Hematologic System
☐	☐	Neck	☐	☐	Immune System
☐	☐	Nodes	☐	☐	Cardiovascular System
☐	☐	Thorax	☐	☐	Musculoskeletal System
			☐	☐	Neurological System
			☐	☐	Behavioral, Psychiatric

Describe any abnormality in detail and/or any condition that requires pre-medication according to AHA or ASOS guidelines prior to dental treatment.

____

____

What pre-medications would be prescribed, what regimen and for what?

____

PART II.

To be completed by a specialist.

EYE EXAM:

Normal ☐ Yes ☐ No

Abnormal ☐ Yes ☐ No

If abnormal, please list the abnormality and recommendations for treatment, if any.

____

____

PHYSICAL EXAMINATION (continued)

PART III.

On the basis of your History and Physical Examination, is it your professional opinion that this person is capable of participating in a dental hygiene program*? ☐ Yes ☐ No

***Dental hygiene involves essential functions such as:**

Mobility	Physical abilities (including standing, walking, bending, range of motion of extremities) to move from room to room and maneuver in small spaces.	Able to administer cardiopulmonary resuscitation; move around in patient treatment area.
Motor	Gross and fine motor function sufficient to provide safe and effective dental hygiene care.	Able to use dental instruments, manipulate various dental materials.
Hearing	Auditory ability sufficient to monitor and assess health needs.	Able to listen to breath and heart sounds. Able to hear equipment monitors, such as x-ray equipment and autoclave timers.
Visual	Visual ability sufficient to provide safe and effective dental hygiene care.	Able to observe patients and use instruments in the oral cavity. Adequate close vision to see small lesions and deposits on teeth.
Cognitive	Critical thinking ability Verbal and written communication skills	Cause and effect relationships in clinical diagnosis and effective interaction with patients and other health care professionals

What restrictions, if any, would you advise?____

____

Any allergies? ____

____

Drug sensitivities? ____

____

Is applicant free of communicable disease? ☐ Yes ☐ No

Comments ____

____

TESTS REQUIRED ON ALL STUDENTS.

Attach duplicates of laboratory test results. Students must attach lab results to physical exam form prior to submission. **DO NOT HAVE RESULTS MAILED SEPARATELY.**

Blood	Urine	Drug Testing
1. CBC 2. Serology (RPR)	1. Microscopic urinalysis	Five panel drug screening

Skin: Complete one of the following

1. **TUBERCULIN (PPD. This test or chest x-ray must be repeated annually.)**

Date given:____________ Date read:____________ Results:____________ or

2. Chest x-ray if one has had a previously positive skin test. (Attach duplicate of x-ray report, if applicable.)

PHYSICAL EXAMINATION (continued)

Titers required:

RUBELLA TITER: Immune: ☐ Non-Immune: ☐
Required for male and female applicants.
Immunization required if non-immune. (Record below)
Date of testing:_______________

RUBEOLA

History of Rubeola: ☐ Yes ☐ No ☐ Unsure
A rubeola titer or proof of immunity is required.
Date of testing:_______________ Immune: ☐ Non-immune: ☐

Immunization required if non-immune: (Record below)

MUMPS

History of Mumps: ☐ Yes ☐ No ☐ Unsure
A mumps titer or proof of immunity is required.
Date of testing:_______________ Immune: ☐ Non-immune: ☐

Immunization required if non-immune: (Record below)

REQUIRED IMMUNIZATIONS:

Rubella, Rubeola, and Mumps if not immune and not contraindicated. . . . .Dates and types of vaccine:

Type of vaccine(s) given:__________
Date of vaccine(s) given:__________
Type of vaccine(s) given:__________
Date of vaccine(s) given:__________

CHICKEN POX

History of Chicken Pox: ☐ Yes ☐ No ☐ Unsure
If Unsure or No, a F.A.M.A. Varicella titer is required.

Date of testing:_______________ Immune: ☐ Non-Immune: ☐

If titer is negative vaccination is required.
Date 1st dose___________
2nd dose___________

Note: Pregnant women cannot receive some vaccines and need to consult their physicians.

Hepatitis B
Date 1st dose___________
2nd dose___________
3rd dose___________

Tetanus within last 10 years: Date:_______________

______________________________ ______________________________
Physician's Signature Date

Please Print

Physician's Name ______________________________

Office Address ______________________________

____

Physician’s Phone ______________________________