



**PRAIRIE STATE COLLEGE  
PHYSICAL EXAMINATION  
DENTAL ASSISTING CERTIFICATE PROGRAM**

**Applicant Name:** \_\_\_\_\_  
*First Name* *Last Name*

**HEALTH HISTORY**

**To be completed by APPLICANT. Please check all problems you have or have had.**

- | <b>Yes</b>               | <b>No</b>                |  | <b>Yes</b>               | <b>No</b>                |                               |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Eye or vision                               | <input type="checkbox"/> | <input type="checkbox"/> | 13. Joint pain                |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Ear or hearing                              | <input type="checkbox"/> | <input type="checkbox"/> | 14. Headaches or seizures     |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Mouth or teeth                              | <input type="checkbox"/> | <input type="checkbox"/> | 15. Skin rashes, lesions      |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Nose or throat                              | <input type="checkbox"/> | <input type="checkbox"/> | 16. Urinary problems          |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Cough, sputum, difficulty breathing         | <input type="checkbox"/> | <input type="checkbox"/> | 17. Rectal problems           |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Breast lumps, enlargements, nipple drainage | <input type="checkbox"/> | <input type="checkbox"/> | 18. Female: vaginal           |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Heart disease/hypertension                  | <input type="checkbox"/> | <input type="checkbox"/> | 19. Male: prostate problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Swollen lymph nodes                         | <input type="checkbox"/> | <input type="checkbox"/> | 20. Emotional illness         |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Indigestion, pain or food intolerance       | <input type="checkbox"/> | <input type="checkbox"/> | 21. Diabetes                  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Bowel-constipation, diarrhea               | <input type="checkbox"/> | <input type="checkbox"/> | 22. Allergies                 |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Cancer                                     | <input type="checkbox"/> | <input type="checkbox"/> | 23. Chemical dependency abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Muscle pain, weakness                      | <input type="checkbox"/> | <input type="checkbox"/> | 24. Other:                    |

**TO BE COMPLETED BY A LICENSED HEALTH PRACTITIONER (M.D., D.O., P.A., A.R.N.P.)**

**TO THE LICENSED HEALTH PRACTITIONER:**

The above applicant is requesting admission into the dental assisting certificate programs at Prairie State College. A physical examination is required to ascertain whether the applicant's has the physical and emotional stamina to perform occupational skills in the classroom and clinical settings. Should you have questions regarding the form, please call the Dean of Allied Health & Emergency Services at (708) 709-2947. The above "Health History" portion of the form should be completed by the applicant, prior to the physician's examination. Pages 2-4 should be completed by the licensed health practitioner.

## PHYSICAL EXAMINATION

**If “Abnormal” is checked, please provide an explanation.**

Normal	Abnormal		Document Abnormalities
<input type="checkbox"/>	<input type="checkbox"/>	Ears, Hearing	
<input type="checkbox"/>	<input type="checkbox"/>	Eye, Vision	
<input type="checkbox"/>	<input type="checkbox"/>	Nose, throat sinuses	
<input type="checkbox"/>	<input type="checkbox"/>	Mouth, teeth	
<input type="checkbox"/>	<input type="checkbox"/>	Neurologic	
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	
<input type="checkbox"/>	<input type="checkbox"/>	Integumentary	
<input type="checkbox"/>	<input type="checkbox"/>	Reproductive	
<input type="checkbox"/>	<input type="checkbox"/>	Hematologic	
<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic	

**Does applicant have a history of any of the following (Check all that apply):**

<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Joint Pain
<input type="checkbox"/>	Muscle Pain
<input type="checkbox"/>	Diabetes

**To the best of my knowledge, applicant appears to be free of infectious disease.**

Yes      No

**Has applicant had any medical/surgical problem that has required treatment in the past 2 years?**

Yes      No

If yes, describe medical/surgical and provide date:

**Please list any medications, which the patient is taking on a continuing basis:**

## Required Vaccinations and Titers

**Please provide applicant with copies of laboratory results that reflect titer results for the following:**

- Mumps Titer
- Rubeola (Measles) Titer
- Varicella (Chicken Pox) Titer

### **Hepatitis B Vaccines:**

Dates: Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_ Dose 3 \_\_\_\_\_

### **Tetanus-diphtheria (Td) or tetanus toxoid, within the last 10 years.**

Date of Tdap vaccine: \_\_\_\_\_

### **Quantiferon Gold 2 step TB Test**

Illinois Department of Public Health has determined that a Quantiferon Gold TB test is preferable in comparison to the two-step TB skin test.

Results of the Quantiferon Gold 2 step:  Negative  Positive

Results of TB test dates: Date #1 \_\_\_\_\_ Results \_\_\_\_\_, Date #2 \_\_\_\_\_  
Results \_\_\_\_\_

## Verification of Ability to Perform Essential Skills and Abilities

Essential Skills and Abilities	Description
<b>Physical Strength and Endurance</b>	<ul style="list-style-type: none"> <li>• Stoop, bend, squat, reach overhead while maintaining balance</li> <li>• Ability to push/pull and lift objects more than 50-100 pounds</li> <li>• Perform patient care for 8-12 hours; stand for prolonged periods of time</li> </ul>
<b>Motor Skills</b>	<ul style="list-style-type: none"> <li>• Manual finger dexterity and hand-eye coordination</li> <li>• Physical abilities (including standing, walking, bending, range of motion of extremities) to move from room-to-room and maneuver in small spaces</li> <li>• Gross and fine motor function sufficient to manipulate instruments to provide safe and effective dental care</li> <li>• Tactile sensitivity sufficient for the use and control of small instruments</li> </ul>
<b>Communication Skills</b>	<ul style="list-style-type: none"> <li>• Abilities sufficient for effective interaction with others in spoken and written English</li> <li>• Ability to accurately transfer gathered data into a patient record</li> <li>• Ability to read and understand technical and professional materials</li> <li>• Ability to demonstrate sensitivity, confidentiality and respect when speaking with patients, peers, faculty and staff</li> </ul>
<b>Sensory Capabilities, Hearing, and Visual Requirements</b>	<ul style="list-style-type: none"> <li>• Normal range hearing, either corrected or uncorrected, for functional use</li> <li>• Normal or corrected visual acuity sufficient for observation of oral conditions and to determine changes in patient status through visual observation</li> <li>• See differences between colors, shades, and brightness</li> <li>• Ability to discern subtle changes in radiographic density and see in darkroom conditions</li> <li>• Ability to clearly see the patient's teeth from a distance</li> </ul>
<b>Intellectual, Conceptual and Cognitive Skills</b>	<ul style="list-style-type: none"> <li>• Ability to concentrate on moderate to fine detail with frequent interruption</li> <li>• Ability to attend to multiple functions and patients often for an extended period of time</li> <li>• Critical thinking and problem solving ability sufficient for clinical judgement</li> <li>• Ability to select and use technical principles, ideas, and theories in a problem-solving situation and adjust procedures accordingly</li> <li>• Ability to work independently and as a team</li> </ul>
<b>Professional Attitude and Demeanor</b>	<ul style="list-style-type: none"> <li>• Ability to present professional appearance</li> <li>• Ability to implement measures to maintain own physical and mental health and emotional stability</li> <li>• Emotional and mental health necessary to effectively apply knowledge and exercise appropriate judgment</li> <li>• Ability to demonstrate flexibility and adaptability</li> <li>• Ability to practice honest and ethical behavior and accountability</li> <li>• Ability to self-evaluate</li> <li>• Ability to demonstrate respect for individuals of diverse ethnic, social, emotional and intellectual backgrounds, religion and/or sexual orientation</li> <li>• Ability to conduct self in a professional manner at all times</li> </ul>

***The applicant is capable of performing all essential skills as abilities as described above and is capable of participating in lecture, lab and clinical experiences without restrictions.\*\****

Yes       No

***\*\* if restrictions are required please provide detailed description of needed restrictions.\*\****

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**Healthcare Practitioner Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE PRINT**

Healthcare Practitioner Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone: \_\_\_\_\_