

PHYSICAL EXAMINATION

Name: _____ Phone: _____
(Area Code)

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 classes.

PART I.

Vital Signs:

Temperature _____ Pulse _____ Respiration _____ Blood Pressure _____

Height _____ Weight _____

Record Findings, Indicating Normal and Abnormal

Normal	Abnormal		Normal	Abnormal	
<input type="checkbox"/>	<input type="checkbox"/>	Skin and Nails	<input type="checkbox"/>	<input type="checkbox"/>	Heart
<input type="checkbox"/>	<input type="checkbox"/>	Head	<input type="checkbox"/>	<input type="checkbox"/>	Breasts
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Ears	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	Nose and Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	Rectum
<input type="checkbox"/>	<input type="checkbox"/>	Mouth and Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular
<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Neurological
<input type="checkbox"/>	<input type="checkbox"/>	Thorax	<input type="checkbox"/>	<input type="checkbox"/>	Mental Status

Describe any abnormality in detail.

PART II.

Please list any prescribed medications/treatments the applicant is receiving:

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

What restrictions, if any, would you advise? _____

Any allergies? _____

Drug sensitivities? _____

Is applicant free of communicable disease? Yes No

Comments _____

PHYSICAL EXAMINATION (continued)

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

1. CBC
2. Serology (RPR)

Urine

1. Microscopic urinalysis

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.)

Titers required:

RUBELLA TITER:

Required for male and female applicants.
Immunization required if non-immune. (Record below)
Date of testing: _____

Immune:
Non-Immune:

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 _____