LAKELAND COMMUNITY COLLEGE

DENTAL ASSISTANT STUDENT HEALTH RECORD

— PLEASE PRINT ALL ENTRIES —

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	Lakeland ID	GENDER

STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE	PHONE

PERSON TO CONTACT IN CASE OF EMERGENCY	PHONE	ALTERNATE PHONE

STUDENT HEALTH HISTORY

This portion of the form is to be filled out COMPLETELY before submitting to your physician.

CONDITIONS	Do you NOW have any of these conditions?		If yes, age at which you developed any of the conditions listed.			Indicate by check if blood relative has had any of these conditions.			
	YES	NO	12 or under	13-18	19 or over	FATHER	MOTHER	BROTHER	SISTER
1. Cancer									
2. Diabetes									
3. Heart Disease									
4. Kidney Disease									
5. Nervous or Emotional Condition									
6. Tuberculosis									
7. Asthma									
8. Convulsions									
9. Epilepsy									
10. Hay Fever									
11. Headaches (Frequent)									
12. Hernia									
13. Menstrual Cramps (Severe)									
14. Mononucleosis									
15. Pneumonia									
16. Polio									
17. Rheumatic Fever									
18. Scarlet Fever									

CHECK WHICH LEVEL OF HEALTH APPLIES TO THE FOLLOWING:	EXCELLENT	FAIR	POOR	DECEASED
YOURSELF				
FATHER				
MOTHER				
SPOUSE				

CHECK YES OR NO FOR EACH OF THE FOLLOWING, AND/OR FILL-IN BLANKS AS INDICATED.	YES	NO
Have you ever had any significant injuries or operations?	❑	❑
If so, explain and give dates: _____		
Are you allergic to any drugs or medication?	❑	❑
If so, name: _____		
Are you allergic to insect bites?	❑	❑
Are you allergic to pollen?	❑	❑
Do you take any kind of drug(s) or medication(s) frequently?	❑	❑
If so, name: _____		
Do you have any physical impairment such as loss of vision that will require preferential seating?	❑	❑
If so, name: _____		
Do you have any voice or speech difficulties which make it difficult for others to understand what you say?	❑	❑
Do you have any difficulty hearing what others say?	❑	❑
Are you covered by any hospitalization insurance?	❑	❑
If so, attach a copy of the card: _____		
Additional comments: _____		
_____		

Student has no physical or mental illness or condition which, even with reasonable accommodation on the part of the Hospital or Affiliating School, could be detrimental to the welfare of, or interfere with, the care of any Hospital's patients.

I hereby give consent to the College Health Services to release a copy of this Health Record to the Dental Assisting Director and the Dean of Science and Health and Clinical sites.

Student's Signature	*Date*

HEALTH EXAMINATION BY PHYSICIAN

Doctor: Please complete this form.

LAST NAME (PLEASE PRINT) _____ FIRST NAME _____ M.I. _____

REQUIRED

HEIGHT	WEIGHT	B/P	URINALYSIS	BLOOD
		PULSE	Albumen _____ Sugar _____	CBC Lab Report — **MUST** — be attached to this form.

RECOMMENDED

VISION: Right _____ Left _____ Corrected Right _____ Left _____

HEARING: Right _____ Left _____

CHECK NORMAL OR ABNORMAL FOR EACH OF THE FOLLOWING. ENTER "N.E." IF NOT EVALUATED

		NRML	ABNRML		NRML	ABNRML		NRML	ABNRML
1.	HEAD, NECK, FACE and SCALP			10. HEART (Include estimate of cardiac function)			16. UPPER EXTREMITIES		
2.	NOSE and SINUSES						17. LOWER EXTREMITIES		
3.	MOUTH and THROAT			11. VASCULAR SYSTEM (Include varicosities)			18. FEET		
4.	TEETH and GINGIVA						19. SPINE (Other musculo-skeletal)		
5.	EARS – GENERAL (Canals, etc.)			12. ABDOMEN AND VISCERA (Include hernia)					
6.	DRUMS (Perforations, etc.)						20. SKIN and LYMPHATIC (Include acne)		
7.	EYES (Lids, Conjunctiva, etc.)			13. ANO-RECTAL and PILONIDAL					
8.	PUPILS and OCULAR MOTION			14. ENDOCRINE SYSTEM			21. NEUROLOGIC		
9.	LUNGS, CHEST and BREASTS			15. G.U. SYSTEM			22. PSYCHIATRIC		

Give the corresponding number of the abnormality and the details which accompany it. (Please print or type.)

_____

CHECK YES OR NO FOR EACH OF THE FOLLOWING, AND/OR FILL-IN BLANKS AS INDICATED. — **YES** **NO**

Student MAY participate in unlimited physical education and intramural activities. ..... ❑ ❑
If limited, to which activities and why? (Please be specific.) _____

_____

Is the student receiving medication regularly? ..... ❑ ❑

If yes, which medications(s)? (Please be specific.) _____

Is there any physical condition (e.g., epilepsy, fainting, diabetes, paralysis) which would limit the student's participation in hospital, classroom or clinical activities? ..... ❑ ❑

If yes, please explain.) _____

IMMUNIZATION SECTIONS ARE TO BE COMPLETED BY PHYSICIAN

REQUIRED IMMUNIZATIONS & TITERS (Dates MUST be in MM/DD/YY format.) ATTACH LAB REPORTS.

Td or Tdap Date Basic Series Completed: _____ Date of Last Td or Tdap Booster: _____

(Must have Basic DPT or Td Series plus a Booster every 10 years.)

Rubella (German Measles) **Vaccination date**_____ **or** Titer Date: _____ **and** Titer Results: _____

Rubeola (Measles) **Vaccination date**_____ **or** Titer Date: _____ **and** Titer Results: _____

Mumps **Vaccination date**_____ **or** Titer Date: _____ **and** Titer Results: _____

Varicella (Chicken Pox) **Vaccination date**_____ **or** Titer Date: _____ **and** Titer Results: _____

Hepatitis B Vaccine Date Basic Series Completed: 1st Dose _____ 2nd Dose _____ 3rd Dose _____
and Titer Date: _____ Results after completion of series: _____

2-Step TB Test Date given: _____ Date read: _____ Date given: _____ Date read: _____ Results: _____
*(Intracutaneous **[MANTOUX]** test only. Required prior to the start of the program.)*

Please indicate if there is a history of a positive tuberculin test. Date: _____ Type: _____

Chest X-Ray Date given: _____ Results: _____
(Required six months prior to starting the program for known positive skin reactors.)

Recommended:

Polio Vaccination Date: _____,_____Titer Date: _____ Titer Results: _____

PLEASE TYPE OR PRINT. ***PLEASE ATTACH CBC.***

Physician's Name:

Address:

Phone:

_____ ***Physician's Signature*** _____ ***Date of Exam***

NOTE: Student must bring this form to Health Services, H-164, Lakeland Community College, 7700 Clocktower Drive, Kirtland, OH 44094-5198.

02-03-20