Stony Brook Medicine

Dear New Dental Assistant Student

Please make sure all of the following items are completed for your Dental Assistant Program Health Form before submitting to Stony Brook Family and Preventive Medicine Services.

Required Items for Dental Assistant Program Health Form

☐ **Health Form Completed by Provider:** I have had a physical exam completed, signed and stamped by a licensed healthcare provider **within 6 months** of my enrollment start date.

☐ **Tuberculosis Screening With 2-Step PPD or an IGRA blood test**

☐ I have submitted documentation of two separate PPD Mantoux skin tests placed at least one week apart. The first PPD is within 12 months and the second PPD within 3 months of my enrollment date.

OR

☐ I have submitted a lab report of an IGRA blood test dated within 3 months of my enrollment.

OR

☐ I have a history of positive PPD or IGRA test and have submitted a chest xray report and information on treatment, if received.

☐ **Tetanus Booster within the past 10 years:** I have submitted vaccine records signed by a licensed health care provider demonstrating receipt of the Tetanus vaccine (Tdap or Td) within the past 10 years.

☐ **Hepatitis B Vaccine Records or Signed Declination:** I have submitted vaccine records signed by a healthcare provider demonstrating receipt of three hepatitis vaccines OR I have signed the enclosed Hepatitis B declination form. (Note: vaccine records or signed declination are required regardless of Hep B surface antibody titer result)

☐ **Lab Reports of Titers:** I have submitted **official lab reports** for **ALL** of the following:

□ **Measles**: Immune/Not Immune*

□ **Mumps**: Immune/ Not Immune*

□ **Rubella**: Immune/ Not Immune*

□ **Varicella**: Immune/Not Immune**

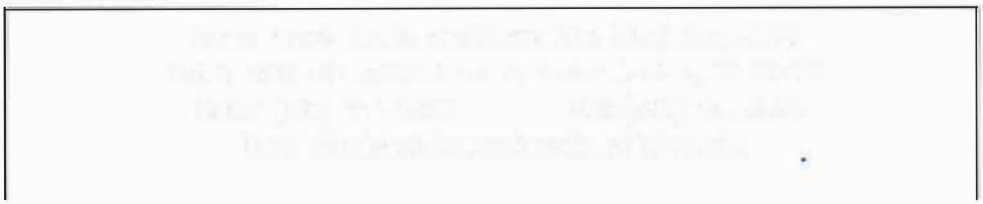
□ **Hepatitis B surface antibody**: Immune/Not Immune

***IF negative titers (not immune) to measles, mumps, or rubella**:

☐ I have submitted vaccine records signed by a licensed health care provider demonstrating receipt of two MMR vaccines (childhood vaccine records acceptable).

****IF negative titers (not immune) to varicella**:

☐ I have submitted vaccine records signed by a licensed health care provider demonstrating receipt of two varicella vaccines (childhood vaccine records acceptable) **OR** I have signed the enclosed varicella declination form.



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Dental Assistant Program Health Form

Name		DOB____/____/____	Best Phone:
Class of	Home Address:		
Email Address:		Emergency Contact: (Name and Phone)	

Medical History: Have you ever had any of the following?

Infectious Diseases	Yes	No	Dates
Chicken Pox or Shingles			
Tuberculosis or **positive** IGRA or PPD test			
Other infectious disease:			
Respiratory/Lungs			
Chronic Bronchitis/Emphysema/COPD			
Asthma/Wheezing			
Asbestosis, Silicosis, Pneumoconiosis			
Pneumonia			
Pneumothorax (collapsed lung)			
Broken ribs or chest injury/surgery			
Coughing up phlegm or blood			
Shortness of breath or chest tightness			
Cardiovascular/Heart			
Heart Attack			
Chest pain/Angina			
Heart failure			
Irregular heart rhythm or palpitations			
High blood pressure			
Edema (swelling of legs/feet)			
Stroke			
Neurologic and Mood			
Seizures or Epilepsy			
Numbness, weakness or paralysis of arms or legs			
Head injury or concussion			
Severe headaches or migraines			
Dizziness or fainting spells			
Other neurologic disorder			
Sleep apnea or other sleeping disorder			
Claustrophobia or anxiety			
Depression, PTSD or other mood disorder			
High stress level			
Reproductive			
Difficulty conceiving			
Current pregnancy			
History of miscarriage/abnormal pregnancy			
Surgeries or Hospitalizations			
Reason:			

Gastrointestinal and Kidney	Yes	No	Dates
Stomach or intestinal problem			
Nausea/vomiting or abdominal pain			
Blood in stool			
Hepatitis or other liver disease			
Kidney disease or kidney stones			
Hernia			
Blood in urine			
Skin, Endocrine, Severe Allergic Reaction			
Chronic rash, eczema, or dermatitis			
Skin sensitivity or other skin problem			
Unusual tiredness or fatigue			
Heat/cold sensitivity or excessive thirst			
Diabetes			
Thyroid or other endocrine problem			
Allergic reactions that affect breathing			
Ears, Eyes, Nose, Throat			
Wear glasses or contacts			
Blurred vision or other vision loss			
Itchy/Watery eyes or eye pain			
Eye injury or disorder (e.g. glaucoma, macular degeneration, cataracts, etc.)			
Color blindness			
Hearing loss or tinnitus (ringing in ears)			
Dental problems			
Frequent sneezing or nasal discharge			
Trouble smelling odors			
Musculoskeletal			
Back or neck injury/pain			
Arthritis/gout			
Muscle pain			
Other bone/joint problem:			
Blood/Immune System/Cancer			
Easy bruising/bleeding			
Anemia			
Enlarged lymph nodes or glands			
Cancer			
Immune system disorder			
Bleeding or clotting disorder			

Please provide details, including dates, for any items marked yes above. Please note any other medical conditions not listed.

_____

_____

_____

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Medications: Please list your current medications (prescription and over the counter, including vitamins/supplements):

_____

_____

_____

_____

Allergies: please specify	**Yes**	**No**
Medication allergies:		
Latex		
Other (e.g. foods, animals, etc.):		
Social History	**Yes**	**No**
Alcohol Use (Circle # of Drinks per Week): None 1 to 5 6 to 14 15 or more		
Tobacco Use (Circle one): Never Former Current (specify #packs/day and #years):		
Do you use any other substances or recreational/street drugs?		
Have you ever received treatment for substance use or abuse?		
Education and Additional History	**Yes**	**No**
Has your physical activity been restricted or your education interrupted for medical reasons in the past 5 years?		
Have you had difficulty with school, studies, or teachers?		
Have you received treatment or counseling for an emotional or psychiatric condition/problem?		
Have you had any illness, injury or hospitalization other than already noted?		
Have you been rejected or discharged from military services because of physical, emotional or other reasons?		

I certify that the above is true and correct to the best of my knowledge.

Patient Signature: _____ **Date:** _____

PART 2: TO BE COMPLETED BY HEALTHCARE PROVIDER

Please review student's history in Part 1 and complete Part 2 below. This student has been admitted to Stony Brook Dental Assistant Program. Information you provide is confidential and will only be used as background to provide healthcare, if necessary, while student is enrolled. Personal medical information will not be released to anyone without the student's knowledge and consent.

REQUIRED IMMUNIZATIONS: OFFICIAL COPIES OF VACCINE RECORDS AND LAB REPORTS REQUIRED!

Mumps, Measles, Rubella	**Date 1**	**Date 2**
List 2 dates of MMR Vaccine (attach copy of official vaccine record or office record if available)		
List any booster doses for mumps, measles, or rubella vaccine		
Measles antibody titer (lab report required, please attach)		
Mumps titer (lab report required, please attach)		
Rubella titer (lab report required, please attach)		

Hepatitis B	**Date 1**	**Date 2**	**Date 3**
List dates of THREE doses of Hepatitis B vaccine and attach copy of official vaccine record OR student may sign Hep B vaccine declination			
Hepatitis B surface antibody titer (lab report required, please attach): (Titer required even if student declines Hep B vaccination)			

Varicella	**Date 1**	**Date 2**
If negative varicella titer, list 2 dates of varicella vaccine (attach copy of official vaccine record)		
Varicella antibody titer (lab report required, please attach):		

Tetanus	**Date**
List date of tetanus vaccine within past 10 years (attach copy of vaccine record)	

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TUBERCULOSIS SCREENING: To be completed by Healthcare Provider	
If student has history of POSITIVE Tb screening test:	**Date**
Date of positive PPD or Quantiferon:	
Date of chest x-ray (must attach x-ray report)	
If treated, please specify dates and medication(s):	

If student has NO history of positive Tb screening test, a 2-step PPD test is required (or IGRA test within 3 months)

Date Placed:____/____/____ Manuf:_____ Lot #:_____ Exp Date:____/____/____

Date Read: ____/____/____ Result: Neg ____mm Pos____mm

Signature: _____ Print Name:_____ License #:_____

***** A 2nd PPD must be placed at least 1 week after 1st PPD for new students***

Date Placed:____/____/____ Manuf:_____ Lot #:_____ Exp Date:____/____/____

Date Read: ____/____/____ Result: Neg ____mm Pos____mm

Readings accepted by MD/DO, PA, NP or Student Health RN only

Signature: _____ Print Name:_____ License #:_____

OR ☐ **Lab report** of IGRA test (Quantiferon, T-spot, etc.) within 3 months of enrollment is attached in place of 2-step PPD

PHYSICAL EXAMINATION

Vitals: Ht: Wt: BP: Pulse: Vision: R 20/___ L 20/___ B 20/___ Corr? Y / N

	Normal	Abnormal		Normal	Abnormal
Head, Ears, Nose, Throat			Abdominal		
Eyes			Genitourinary		
Neck-Thyroid			Musculoskeletal		
Respiratory			Skin/Endocrine		
Cardiovascular			Neuro/Psychiatric		

Please describe any abnormalities on physical exam or history:

Questions for Healthcare Provider	Yes	No
To the best of your knowledge, is this person **free from physical or mental impairments, including alcohol or drug dependency?**		
Is this person **free from any activity limitations or needed accommodations**? If not, please note below:		

How long and in what capacity have you known this student?

After physical examination and review of medical history, immunization history and TB screening, I find this individual to be free from health impairment which might interfere with the performance of his/her duties as per NYS Health Code (Title 10, Section 405.3) and Stony Brook School of Dental Medicine policy.

Examining Practitioner's Signature: _____ **Date:** _____

Printed Name: _____ **License # and State:** _____

Address: _____ **Phone:** _____

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Varicella Vaccine Declination

If you do not have a positive varicella antibody titer or documentation of two doses of varicella vaccine, you MUST sign the varicella declination statement below

I understand that varicella is a potentially serious, vaccine-preventable disease and that I may be at risk of acquiring and transmitting the disease.

Student Printed Name	Student Signature	Date

Hepatitis B Vaccine Declination

If you do not have documentation of a completed three dose series of Hepatitis B vaccine, you MUST sign the declination statement below

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection.

Please check one box below:

- ☐ I am in progress with my Hepatitis B vaccine series and have received _____(number completed) of vaccines. I have attached evidence of initiation of the vaccine series. I understand that I will not be considered to have developed lifelong immunity to Hepatitis B until I complete the 3-shot vaccine series and obtain a positive Hepatitis B surface antibody titer. I expect to complete the vaccine series by the following date_____.
- ☐ I have previously received the complete Hepatitis B vaccination series but do not possess vaccine documentation. I have been given the option of revaccination with the Hepatitis B series but decline.
- ☐ The vaccine is contraindicated for medical reasons
- ☐ I have completed the Hepatitis B vaccination series twice and did not develop positive antibody titers following vaccination. I am thus considered a Hepatitis B vaccine non-responder and will submit supporting documentation (i.e. two complete Hepatitis B vaccine series AND lab reports of negative post-vaccination Hepatitis B surface antibody titers AND lab reports of negative Hepatitis B surface antigen and negative total Hepatitis B core antigen (anti-HBc)). I have received counseling regarding precautions to prevent Hepatitis B and the need to obtain Hepatitis B immunoglobulin (HBIG) prophylaxis in the event of an exposure to Hepatitis B.
- ☐ None of the above apply. I am declining the Hepatitis B vaccine series at this time.

Student Printed Name	Student Signature	Date