DENTAL EXAMINATION (please print in black ink) **To be completed and signed by Dentist**

This form must be completed within 6 months of start of program and signed by a dentist.

Last Name	**First Name**	**Middle Name**	**Date of Birth (month/day/year)**	**Examination Date**

EXTRA-ORAL EXAMINATION			**INTRA-ORAL EXAMINATION**		
	Normal/Variant	**Abnormal**		**Normal/Variant**	**Abnormal**
Overall Appearance			Breath Odor		
Face			Saliva		
Ears			Lips:		
Skin			a. Upper		
Eyes			b. Lower		
Lymph Nodes:			Labial & Buccal Mucosa		
a. Occipital			Mucobuccal Fold		
b. Auricular			Hard Palate		
c. Superficial Cervical			Soft Palate		
d. Deep Cervical			Maxillary Tuberosities		
e. Submental			Retromolar Pads		
f. Submandibular			Tongue:		
g. Other			a. Dorsum		
			b. Lateral		
Glands:			c. Ventral		
a. Parotid			Floor of Mouth:		
b. Submandibular			a. Anterior		
c. Sublingual			b. Posterior		
d. Thyroid					
Larynx			Pharynx		
Hyoid Bone			Tonsilar Area		
Muscles:			Alveolar Process		
a. Masseter			Other:		
b. Temporalis					
c. Sternocleidomastoid					
d. Mylohyoid					
TemporoMandibular Joint:					
a. Right					
b. Left					

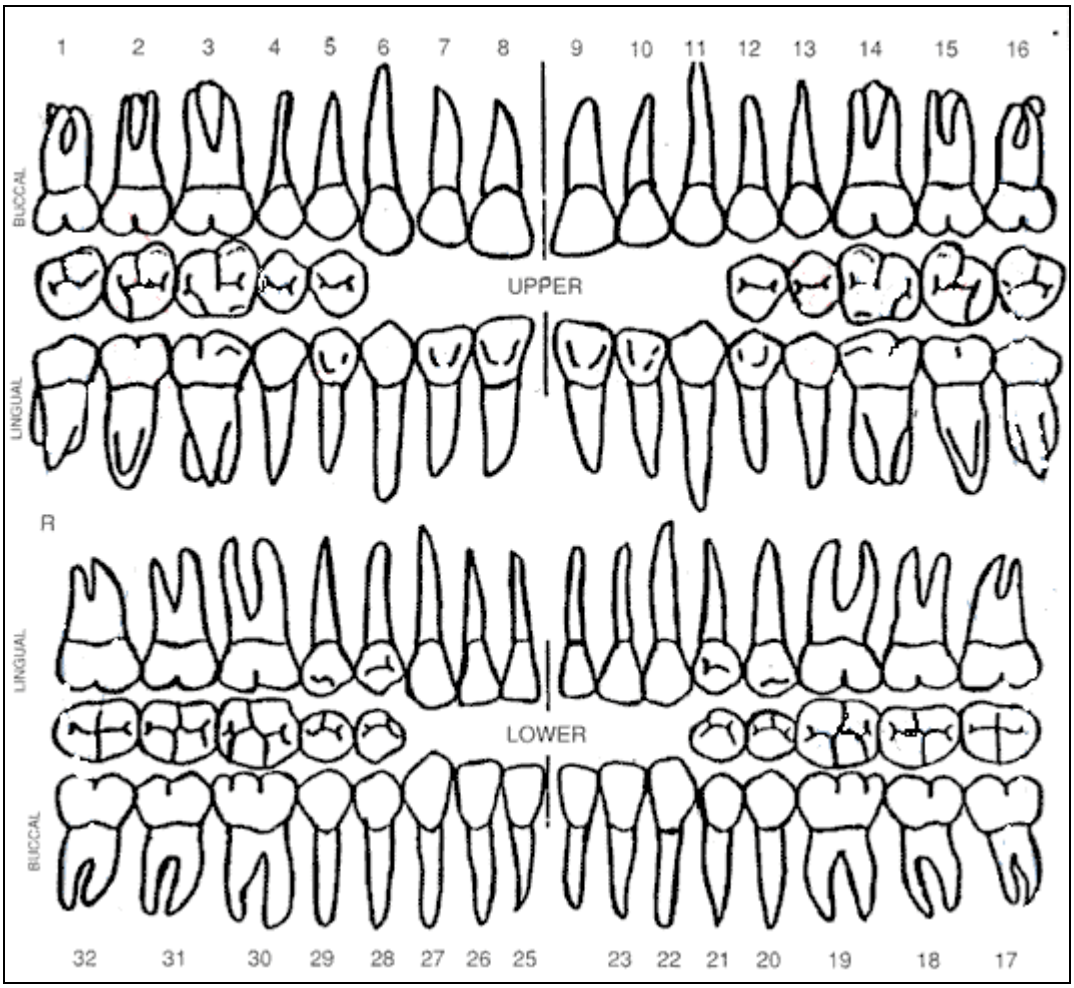
DENTAL EXAMINATION

Please briefly describe condition of teeth:	Recommended treatment:

DENTAL EXAMINATION-continued (please print in black ink) **To be completed and signed by Dentist**

Student's Name **Date**

Please indicate all work to be done by marking the appropriate tooth/teeth in Red and crossing-out missing teeth in Blue.



Please describe the condition of teeth:

DENTAL EXAMINATION-continued (please print in black ink) **To be completed and signed by Dentist**

OCCLUSION, ANOMALIES, and ORAL HABITS	
Class: _____	Oral Habits:
Deviations from Normal:	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	Tooth Anomalies:
_____	_____
_____	_____
_____	_____
_____	

PERIODONTAL EXAMINATION	
	Description (please specify)
Color	
Contour	
Texture/Consistency	
Size	
Mobility	
Recession	
Bleeding	
Exudate	
Sulcus depth	
Amount of attached gingiva	
Furcation involvement	

_____ _____
Signature of Dentist Date

_____ _____
Print Name of Dentist State License Number

_____
Office Address and Telephone Number (*Clinic stamp is acceptable*)

STUDENT HEALTH HISTORY (please print in black ink) **To be completed by Student**

LAST NAME (print) FIRST NAME MIDDLE NAME SFSC STUDENT NUMBER

PERMANENT ADDRESS CITY STATE ZIP AREA CODE/PHONE NUMBER

DATE OF BIRTH (month/day/year) _____ **GENDER**: ☐ M ☐ F **MARITAL STATUS**: ☐ S ☐ M ☐ Other

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require fuller explanation.

FAMILY & PERSONAL HISTORY (please print in black ink) To be completed by student

Has any person, related by blood, had any of the following:

	Yes	No	Relationship		Yes	No	Relationship
Diabetes				Psychiatric illness			
Stroke				Suicide			
Glaucoma				Alcohol/Drug problems			
High blood pressure				Blood/clotting disorder			
Heart attack before age 55				Cholesterol or blood fat disorder			
Cancer (type:)				Respiratory Illness: (specify)			

HAVE YOU EVER HAD OR HAVE YOU NOW: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year		Yes	No	Year
Diabetes				Frequent sore throat			
Cardiovascular disease				Swelling of ankles, feet, or legs			
High blood pressure				Systemic lupus erythematosus			
Tuberculosis				Thyroid problems/disease			
Arthritis or joint problems				Frequent/Severe headaches			
Sickle cell/Anemia				Severe head injury or concussion			
Asthma/Respiratory illness				Persistent swollen glands in neck			
Bacterial endocarditis				Typhoid fever			
Chest pain upon exertion				Rheumatic fever			
Chicken Pox (Varicella virus)				Anxiety or Severe depression			
Chronic diarrhea				Pilonidal cysts (skin cysts)			
Epilepsy/Seizures				Mononucleosis			
Fainting spells/Dizziness				Neck injury			
Hearing deficit or loss				Back problems/Recurrent back pain			
Hepatitis				Heart problems/disease			
Hernia or rupture				Cardiovascular disease			
Herpes				Paralysis			
Immunosuppression				Varicose veins/painful leg veins			
Jaundice				Pertussis (whooping cough)			
Low blood pressure				Skin disease (eczema, psoriasis, etc)			
Malaria				Alcohol or Drug use			
Measles				Shortness of Breath			
Meningitis				Smoke: # of cigarettes a day _____			
Mumps				Hand or wrist problems			
Neurological disorders				Eye trouble excluding glasses			
Ulcer (duodenal or stomach)				Shoulder/Joint dislocations			
Protein or Blood in urine				Bronchitis or Pneumonia			
Sexually transmitted disease				Blood disease			
Psychiatric disorders				Emphysema			
Rubella				C.O.P.D.			
Sinus problems/Sinusitis				Broken bone: (specify)			
Tumor/Cancer: (specify)				Other: (specify)			

Please list any medicines, birth control pills, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

FAMILY & PERSONAL HISTORY-CONTINUED (please print in black ink) **To be completed by Student**

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, rash, etc.) to any of the following? If yes, please fully explain the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Allergies	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies			
Latex products			
Do you have any other allergies or have you had any other reactions that are not mentioned above?			
Hospitalization/Surgery	**Yes**	**No**	**Explanation**
Have you ever been a patient in any type of hospital setting? (Specify when, where, and why)			
Have you ever been treated, hospitalized or are you presently on medication for emotional problems?			
Is there loss of or seriously impaired-function of any paired organ? (Please describe)			
Other than for a routine checkup, have you seen a physician or healthcare professional in the past 6 months? (Please describe)			
Have you ever had a serious illness or injury other than those already noted? (Specify when and where and give details)			
Medications	**Yes**	**No**	**Explanation**
Have you ever taken Pondamin, Redux, or Fen-Phen? (Specify when and for how long)			
Other	**Yes**	**No**	**Explanation**
Do you have any problems manipulating small objects with your fingers?			
Are you currently under the care of a physician for any other conditions? (Please describe)			

IMPORTANT INFORMATION…..PLEASE READ CAREFULLY AND COMPLETE

STATEMENT BY STUDENT:

I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless by Court order.

_____ _____

Signature of Student Date

PHYSICAL EXAMINATION (please print in black ink) **To be completed and signed by Physician**

Date of Examination MUST Be Within 3 months of the First Day of Classes.

Last Name	First Name	Middle Name	Date of Birth (month/day/year)	Examination Date

HEIGHT _____ **WEIGHT** _____**Vital Signs: TPR** _____/_____/_____ **BP** _____/_____

(Specialist exams not required)

Vision: Corrected Right 20/_____
Left 20/_____
Uncorrected Right 20/_____
Left 20/_____
Color Vision

Hearing: (gross) Right _____
Left _____
15 ft. Right _____
Left _____

(Required tests)

Urinalysis: Sugar _____ Albumin _____
Micro _____
Hgb or Hct (if indicated) _____

Date _____ Results _____
Recommendations _____
_____
_____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Mouth, Throat			
2. Eyes (Include glasses: reading/continuous)			
3. Cardiovascular (Heart/Circulation evaluation)			
4. Respiratory (Airway/Chest and Lungs)			
5. PPD (If positive, chest x-ray _____Date)			Date _____/_____ Results (If positive, attach report)
6. Abdominal			
7. Endocrine (Include thyroid problems/diabetes, etc.)			
8. Musculoskeletal/Neurological:			
a. Sensory (other than previously noted)			
b. Motor (condition of spine/extremities?)			
11. Skin (Include latex sensitivity)			
12. Rubella/Hepatitis Screen (If no immuniz. proof)			

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____

B. Is student under treatment for any medical, psychological, or emotional condition? Yes _____ No _____
Explain _____

C. Recommendation for physical activity. Unlimited _____ Limited _____
Explain _____

D. Is student physically, psychologically, and emotionally healthy? Yes _____ No _____
Explain _____

Based on my assessment of this student's physical and emotional health on _____, he/she appears able to participate in all activities. Yes _____ No _____ If no, please explain _____
_____

_____ _____
Signature of Physician Date

_____ _____
Print Name of Physician State License Number

Health Sciences Student Health Form

Last Name	First Name	Middle Name	Date of Birth (month/day/year)

Part 1: Immunization Record, PPD and Titers: Please review student's health record and complete the following:

SECTION A - IMMUNIZATIONS

	Vaccination Date			
Tdap (must be within last 10 years)				
	MMR # (date)	**MMR #2 (date)**	**Rubella Titer (IgG)**	**Rubeola Titer (IgG)**
MMR (2 doses or titers to provide proof of immunity)			Immune	Immune
			No immunity	No immunity
	Hep B #1(date)	**Hep B #2(date)**	**Hep B #3 (date)**	
Hepatitis B Series (Must have first in series before start of program)				
	Date Administered	**Date Read**	**Result**	**Provider Signature**
Tuberculin (PPD) Test				
Chest x-ray (if positive PPD)				
	Vaccination Date			
Influenza Vaccine (prior to clinicals, during timeframe of October 1 – March 31)		**Influenza - Recommended, not required for Dental**		

SECTION B – REQUIRED TITERS

	Titer Date	Titer Results
Varicella Antibody Titer (if no immunity, vaccination not required at this time)		Immune
		No immunity
Hepatitis C Antibody Titer (Current titer must be within 6 months of start of program)		Positive
		Negative
Hepatitis B Antibody Titer (IgG) (Upon completion of Hepatitis B series)		Immune
		No immunity

Part 2: Performance Ability:

1. Based on my assessment of this student's physical and emotional status he/she appears to be in good health and capable of performing the duties associated with their respective Health Sciences Program (Program Technical Standards attached)? ☐ **YES** ☐ **NO** (Please check one)

2. If you answered "NO" to the previous question, please document the condition(s) that will prevent this student from performing the duties of their respective Health Sciences Program. _____

_____

Must be completed by a licensed Physician (MD or DO), Physician Assistant or Nurse Practioner.

Provider Name: _____ Provider Phone#: _____

Provider Address: _____ Provider License #: _____

Provider Signature: _____ Date: _____

South Florida State College
Dental Program

Hepatitis B Vaccination and Titer Form

(This form to be used to document subsequent vaccinations & titer results)

Student Name: _____ Date of Birth: _____

1. Hepatitis B Vaccination Series:

Hep B #1 (date)	Hep B #2 (date)	Hep B #3 (date)

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

2. Titer to be done at least 6 weeks after completing Hepatitis B vaccination series:

Required Titer	Titer Date	Titer Results	Immune	Not Immune
Hepatitis B Antibody Titer (IgG)				

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

South Florida State College
Dental Program

Annual Tuberculosis Testing Form

(This form to be used to document subsequent vaccinations & titer results)

Student Name: _____ Date of Birth: _____

History of negative PPD: yearly update required

	Date Administered	Date Read	Result	Provider Signature
Tuberculin PPD Test				
Chest X-ray (if skin test positive)				

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

South Florida State College
Dental Program

Annual Influenza Vaccination Form

(This form to be used to document subsequent vaccinations & titer results)

Influenza vaccine is not required for dental students; however, it is recommended.

Student Name: _____ Date of Birth: _____

	Date Administered	Injection Site & Lot Number
Influenza Vaccine		

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

** Have provider complete the above information and sign or attach proof of immunization from provider **

PERFORMANCE STANDARDS

For Admission, Progression and Graduation
In Florida Dental Assisting Programs

Successful participation and completion of a Dental Assisting Program requires that an applicant be able to meet the demands of the program. Dental assisting students must be able to perform academically in a safe, reliable and efficient manner in classrooms, laboratory and clinical situations. The student must also demonstrate behaviors, skills and abilities to be in compliance with legal and ethical standards as set forth by the American Dental Assistants Association Code of Ethics.

All Florida Dental Assisting Programs are committed to the principle of diversity. This program is open to all qualified individuals who apply and complies with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973. Throughout the program, students will be acquiring the fundamental knowledge, attitudes, skills and behaviors that will allow them to successfully complete the program of study and to function as a Certified Dental Assistant. Those attitudes, behaviors, and skills that a person working as a Certified Dental Assistant must possess to practice safely on the job are reflected in the standards that follow.

Students working toward Certification in Dental Assisting must be able to meet these minimum standards, with or without reasonable accommodation, for successful completion of their formal training.

STANDARD	GENERAL PERFORMANCE STATEMENT	ESSENTIAL FUNCTION
Motor Skills	*With or without reasonable accommodation, the student should be able to:* Demonstrate a high degree of manual dexterity and the ability to execute motor movements reasonably required to provide general treatment and emergency care to patients, adequate strength and ability to perform lifting and patient transfers into a dental chair; the ability to maneuver with functional coordination and mobility in small spaces, as well as be sedentary for several hours at a time.	***IT IS REQUIRED THAT THE STUDENT:*** Be independent in mobility to move quickly in and around the classroom, laboratory, and the clinical operatory. - Provide for patient safety and well being in positioning of dental chair, dental light and x-ray equipment. - Quickly move from different positions, as required, to perform chairside clinical skills as well as be prepared to administer emergency care procedures. - Exhibit sufficient manual dexterity to manipulate and control small motor driven equipment. - Perform instrument transfer using only fingers, wrist and elbow. - Perform skills with hand instruments during patient care. - Perform complex motor tasks necessary to take alginate impressions, make temporary crowns, take intraoral radiographs, and execute other specialty functions as required. - Move adequately from sterilization, reception room, business office, x-ray rooms and clinical operatories. - Successfully complete a CPR certification course.

STANDARD	GENERAL PERFORMANCE STATEMENT	ESSENTIAL FUNCTION
Visual	*With or without reasonable accommodation, the student should be able to:* Demonstrate visual acuity and perception sufficient for observation and recognition of patient needs to insure safe and effective chairside performance.	***IT IS REQUIRED THAT THE STUDENT:*** Observe lectures, and laboratory demonstrations. - Receive information via visual observation of oral tissues with regard to normal and abnormal conditions. - Demonstrate normal color vision sufficient to recognize subtle changes in oral conditions. - Identify types of instruments needed for the areas being treated - Observe and describe the patient's response to care and evaluate the patient's level of oral hygiene.
Tactile	Demonstrate sufficient tactile abilities with both hands to gather dental assessment information and to assist in the delivery of patient care.	Tactily assess and evaluate the status of intraoral structures using instruments on hard tissue. - Use direct palpation techniques to examine the intra-oral and extra-oral soft tissue and to detect a patient's pulse.
Hearing	Demonstrate functional use of hearing to acquire and mentally process information that is dictated as part of a clinical exam or observation.	Hear and obtain appropriate course information from faculty and peers and to process this information for use in laboratory settings and on examinations. - Listen actively. - Acquire accurate medical history and data collection verbally from the patient or guardian. - Audibly ascertain if a patient is experiencing a medical emergency.
Communication	Demonstrate the ability to communicate clearly with patients, physicians, other health professionals, faculty, family members, significant others, caregivers, and community or professional groups and colleagues. Communication includes: verbal and nonverbal expression, reading, writing, computation, and computer skills.	Participate, via in-class and group discussions, in the delivery and receiving of information and to respond to questions from a variety of sources. - Display knowledge of basic written grammar and spelling skills. - Report information accurately and legibly through progress notes in the patient's chart. - Explain recommended treatment, preventive procedures, and the nature of disease processes to patient and/or caregiver in a way that is easily understood. - Communicate effectively by recognizing and respecting the physical and psychological needs of others. - Help maintain open communication and a good rapport with all patients.

STANDARD	GENERAL PERFORMANCE STATEMENT	ESSENTIAL FUNCTION
Interpersonal	*With or without reasonable accommodation, the student should be able to:* Demonstrate the ability to relate to others verbally beyond giving and receiving instruction, and to cooperate with people from a variety of social, emotional, intellectual, religious, and cultural backgrounds.	***IT IS REQUIRED THAT THE STUDENT:*** Develop a concern for others, such as classmates, staff, patients, and faculty. - Cooperate with others and be able to work as a team member. - Acquire the ability to maintain poise and flexibility in stressful or changing conditions. - Recognize and respond appropriately to individuals of all ages, genders, races, sexual preferences, socio-economic, religious and cultural backgrounds.
Self Care	Demonstrate the ability to maintain general good health and self-care in order not to jeopardize the health and safety of self and individuals with whom one interacts with in the academic and clinical setting.	Maintain personal hygiene. - Demonstrate safety habits and work area neatness. - Comply with industry health and safety standards, OSHA guidelines, and material safety data. - Maintain a lifestyle that is consistent with one's educational and professional requirements.
Critical Thinking	Demonstrate critical thinking and ethical decision making ability under stressful conditions, and to apply quick reaction time in an emergency situation.	Apply critical thinking processes to solve work related problems in the classroom and in a clinical setting. - Exercise sound, problem solving decisions in class, laboratory and clinic situations. - Follow safety procedures established for each class, laboratory and clinic. - Identify problems and consider alternatives and consequences of each alternative. - Be able to self-evaluate and strive to improve technical skills. - Take action and be responsible for that decision.
Organizational Skills	Demonstrate the ability to handle multi-tasks simultaneously and to operate in a logical, sequential, and orderly manner.	Organize required classroom assignments, laboratory work, and extra-curricular activities each semester into a realistic workable schedule that will facilitate student learning and success. - Anticipate and prioritize tasks to be done in the patient care setting.

STANDARD	GENERAL PERFORMANCE STATEMENT	ESSENTIAL FUNCTION
Intellectual Abilities	*With or without reasonable accommodation, the student should be able to:* Demonstrate the ability to read, write, speak and understand English at a level consistent with successful course completion and with the development of positive patient-student relationships.	***IT IS REQUIRED THAT THE STUDENT:*** Comprehend and assimilate verbal and written program / course materials. - Perform simple and repetitive tasks. - Learn to reconcile conflicting information. - Use proper punctuation, grammar, spelling in written work that is neat and legible. - Follow verbal and written instructions at a 75% or better level of competency.
Commitment to Learning	Demonstrate a positive attitude toward decision-making policies and program operating rules and procedures, as applied, as well as learn new concepts and abilities within the program's operational policies and methods.	Demonstrate initiative, motivation and a willingness to learn. - Complete reading assignments and other activities in a timely manner. - Complete all work without resorting to cheating or plagiarism. - Attend all class, laboratory and clinicals, as assigned. - Be consistently punctual to all classes, laboratories and clinical assignments.

If a student cannot demonstrate the skills and abilities identified above, it is the responsibility of the student to request an appropriate accommodation. The College will provide reasonable accommodation as long as it does not fundamentally alter the nature of the program offered and does not impose an undue hardship such as those that cause a significant expense, difficulty or are unduly disruptive to the educational process.

I, _____, (***Student Signature***) have read and understand the Essential Functions outlined above as performance standards necessary for being a student in the program and a success in the Dental Hygiene work environment after graduation.

Date: _____

Physical Activity: (NOTE: This section must be completed by a physician)

Student Name _____

Unrestricted: _____ Yes _____ No

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____