COLUMBUS STATE COMMUNITY COLLEGE
Dental Hygiene

HEALTH HISTORY
To be completed by the Student:

PLEASE PRINT ALL INFORMATION **COUGAR I.D.______________**

Name: _______________________________________SS#:_______________________
Last First Middle

Address: ____
Street City State Zip

Date of Birth: ______________________ Phone: ________________________________
Month/Day/Year Home Other

Program of Study: ____

Semester to Begin Program: ____________________ E-mail:_________________________

INSTRUCTIONS FOR COMPLETION OF HEALTH RECORD

1. Please read and follow all instructions so we can process your records as quickly and accurately as possible. If you do not follow instructions or do not submit **complete information**, processing of your health record might be delayed, which might delay your ability to register into your courses. ***All information must be completed before you will be eligible to register.***

2. Answer all questions. If the answer is "no, none, not applicable", write that as your answer. Make certain you have entered your program of study above so we will know which requirements apply to you.
   If you have had a physical examination within the past year you can submit that documentation rather than have another physical at this time IF all of our needed information is on your documentation.

3. It is **your responsibility**, not your physician's, to make certain that all health requirements have been completed and documentation of all items is submitted to the college. Please verify that you have the appropriate documents prior to submitting them to the college.

4. **Remember to make photocopies of this record for your own file prior to submitting your documents to the Health Records Office.**

5. **Allow up to five business days to process your health records.** Records are processed in the order in which they are received. If your health records are submitted **less than five business days** prior to the beginning of the registration period, we cannot guarantee that we can process them before the first day of registration.

6. **Submit completed health record to: Columbus State Community College, Health Records Office, Union Hall Room 132, 550 East Spring Street, Columbus OH 43215; or fax to 614-287-5386, including current name and Cougar ID on all faxed pages. You may also email your Health Record to healthrecords@cscc.edu Emails will only be accepted from your student email account (@student.cscc.edu); documents must be scanned in pdf format, no photos. QUESTIONS?? Call 614-287-2450**

Do you have a sensitivity or allergy to **latex**? No_____ Yes_____

If yes you will need to complete the "Latex Reaction Form" which can be accessed from the college's web site at http://cscc.edu/services/hr_pdf/LatexReactionForm.pdf . Print the form, complete your portion, and then give the form to your physician to complete his or her portion. Your completed Latex Reaction Form must be submitted with the rest of your health record forms.

List all allergies and sensitivities you have including medications, food, & environmental:

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____

List all surgical operations you have had with the date:

____

____

____

List all current health conditions you have:

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____

List any previous significant health problems you have had:

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The information you are reporting to Columbus State Community College is used to provide health information required by the college's clinical affiliates, and to verify your ability to perform essential functions of the clinical tasks safely.

It is the policy of Columbus State Community College not to discriminate against any individual. This assurance of non-discrimination includes applicants for academic admission, and shall be applied regardless of sex, race, color, religion, national origin, ancestry, age, disability, genetic information (GINA), military status, sexual orientation, and gender identity and expression.

I certify that the health information I have given is accurate and complete. I understand that providing false information on this document is a serious offense which will result in disciplinary action. I understand that if my health, physical condition, or physical abilities change during my enrollment in a health-related program at Columbus State Community College I must report these changes to my program coordinator and to the Health Records Office. I understand that physical exam and tuberculin testing results may be released to clinical sites prior to my clinical/practicum experiences. I understand that conditions which may affect my ability to perform essential functions of the clinical tasks or which may affect my ability to function with safety for myself and/or others might be discussed with my department chair or program coordinator.

________________________________ ________________________________

Student Signature Date

COLUMBUS STATE COMMUNITY COLLEGE
HEALTH RECORD

Physical Examination: Must be performed by Physician, Nurse Practitioner or Physician's Assistant

Name: ____ Date of Birth: ____________________
Last First Middle Month/Day/Year

Allergies: ____

Medications: ____

Height: __________ Weight: _________ Pulse: __________ B/P: ____________________

EXAMINER: Indicate your findings after examination of each system

EENT: ____

NEURO: ____

CV: ____

RESP: ____

ENDOCRINE: ____

MUSC/SKEL: ____

- ❑ If this student has any reaction to latex, please complete the Examiner's portion of the "Latex Reactions Form" that the student will supply to you.
- ❑ If this student is subject to any health emergency, please provide special emergency instructions below.
- ❑ If there is additional significant information about this student which would relate to his or her safety for patients or for self in a clinical or laboratory situation, please provide information below.

Does student have any functional limitations or restrictions that would prevent him/her from working in a patient care area?	**Yes**	**No**
Vision, such as reading gauges or thermometers?		
Hearing, such as in a classroom or when using a stethoscope?		
Speech, such as in a classroom?		
Lifting up to 50 pounds?		
Ambulation/Standing for several hours?		
Ability to handle stress?		
Sensorimotor (fine and gross)?		

Does the student have any limitations or restrictions? If no, please document below "No restrictions/No limitations". If **yes**, please provide specific facts regarding student's requirements. ____

____

Examiner's Signature: ____

Print Examiner's Name: ____

Address: ____

Phone: ______________________ Date: ____________________________

COLUMBUS STATE COMMUNITY COLLEGE
HEALTH RECORD

Tuberculosis Testing

Name: ____

Tuberculosis Testing

Two-Step Mantoux (intradermal) is required. This involves two Tb Mantoux tests at least 7 days apart and within the last year. Two or three days after each Tb test is given it must be read by the physician, nurse, or physician's assistant. Tb tine tests are not acceptable per state regulations. Two Mantoux tests within the past year can be substituted per state regulations. If the student recently received an MMR or varicella vaccine, the tuberculosis test must be postponed until at least four to six weeks after the MMR.

Tb#1	**Tb#2** At **least 7 days after the first Tb test**:
Date given: __________	Date given: ______________
Date read: ___________	Date read: ______________
Result: ______________mm	Result: _________________mm
Read by: _____________________	Read by: _________________________

If this test or a previous test is positive: Submit documentation of positive PPD and a negative chest x-ray report from within the past five years. If your previous chest x-ray or positive PPD has been more than a year ago, please complete an Annual Health Evaluation form found at http://cscc.edu/Students/FormsPDF/health/Annual.pdf.

Facility Name: ____

Address: ____

Phone: ________________________ Date: __________________________________

Submit completed health record to: Columbus State Community College, Health Records Office, Union Hall Room 132, 550 East Spring Street, Columbus OH 43215; or fax to 614-287-5386, including current name and Cougar ID on all faxed pages. You may also email your Health Record to healthrecords@cscc.edu Emails will only be accepted from your student email account (@student.cscc.edu) QUESTIONS?? Call 614-287-2450

COLUMBUS STATE COMMUNITY COLLEGE
SUPPLEMENTARY IMMUNIZATION RECORD

NAME ______________________________ SS# ____________________________

PROGRAM __________________________ COUGAR ID#____________________

TO BE COMPLETED BY THE PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT

THE FOLLOWING IMMUNIZATIONS ARE *REQUIRED*:

1. **Hepatitis B**: Dates of Hepatitis B immunization: #1 _______________, #2 _________________, #3______________ (Must have immunizations #1 and # 2 completed before submitting health record and final immunization completed on schedule.)

   OR

   Date and results of hepatitis B **surface antibody** _________________________

   NOTE: If the surface antibody is negative, the student must receive the immunization series.

2. **MMR:** Date of first immunization________________ Date of second_____________________

   OR

   Date and results of Rubeola IGG titer_________________, Mumps IGG titer__________________,

   Date and results of Rubella IGG titer_____________________.

   NOTE: If titer is negative, the student must receive the immunization series.

   DO NOT RECEIVE MMR IMMUNIZATION WHILE YOU ARE COMPLETING THE TWO-STEP TUBERCULOSIS TEST. The measles component invalidates the tuberculosis test, so you would have to repeat the tuberculosis testing which may delay your ability to register into your program.

3. **Chickenpox/Varicella**: Date of first immunization ___________Date of second _____________

   Both immunizations required before submitting health record.

   OR

   Date and results of varicella **IGG** titer ______________________________________

   HISTORY OF DISEASE/ILLNESS IS NOT ACCEPTABLE DOCUMTATION!

   DO NOT RECEIVE THE VARICELLA IMMUNIZATIONS WHILE YOU ARE COMPLETING THE TWO-STEP TUBERCULOSIS TEST.

4. **Tdap**: (Tetanus and Whooping Cough): Date of immunization within past 8 year's __________________

5. **Flu Vaccine: ______________________ (CURRENT SEASONAL FLU REQUIRED)**

Signature: ____

Printed Name and Title: ____

Organization: ____

Phone: ______________________ Date: _______________

Revised 08/21/2018