Oxnard College Student Health Center

4000 S. Rose Ave

Oxnard, Ca 93033

Phone: (805) 678-5832 Fax: (805) 678-5932

**Dental Hygiene Physical**

|  |
| --- |
| This page must be **completely** filled out by you before your appointment.  The Student Health Center at Oxnard College will be happy to assist you in obtaining your physical. Call for an appointment: (805) 678-5832. |

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STUDENT ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have or have you ever been treated for any of the following:

(Explain all yes answers)

|  |  |  |
| --- | --- | --- |
|  | YES/NO | If YES, Explain. |
| 1.Hearing Problems |  |  |
| 2. Do you wear glasses? |  |  |
| 3. Do you wear contacts? |  |  |
| 4. Are you pregnant? |  |  |
| 5..High Blood Pressure |  |  |
| 6. Heart Murmur |  |  |
| 7. Ulcer |  |  |
| 8. Hernia |  |  |
| 9. Kidney/Bladder Infection |  |  |
| 10. Monomucleosis |  |  |
| 11. Frequent Sore Throat |  |  |
| 12. Diabetes |  |  |
| 13. Hepatitis |  |  |
| 14. Seizures |  |  |
| 15. Frequent Respiratory Infection |  |  |
| 16. Tuberculosis |  |  |
| 17. Asthma |  |  |
| 18. Anemia |  |  |
| 19. Frequent Sinus Infection |  |  |
| 20. Tumors |  |  |
| 21. Skin Problems |  |  |
| 22. Cancer |  |  |
| 23. Back Problems |  |  |
| 24. Have you been hospitalized? |  |  |
| 25. Have you ever been treated for psychological problems? |  |  |
| Are you taking any medications? |  |  |
| Do you have any allergies?  Have you ever had any surgeries? |  |  |
| Do you have a condition that is legally defined as a handicap? |  |  |
| Have you had a recent accident or injury? |  |  |

My signature below indicates that all information provided is true and accurate to the best of my knowledge.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_

I grant permission for the release/disclosure of information contained in the psychical exam and among appropriate college staff when necessary for the evaluation of my fitness to enroll.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***(To be filled by health care provider.)***

Ht: \_\_\_\_\_\_\_\_\_ Wt: \_\_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_ Resp: \_\_\_\_\_\_\_BMI:\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| PHYISICAL EXAM | NORMAL/ABNORMAL | COMMENTS |
| 1.Appearance |  |  |
| 2.Skin |  |  |
| 3.Eyes |  | OS:20/\_\_\_\_\_\_  OD:20/\_\_\_\_\_\_  OU:20/\_\_\_\_\_\_ |
| 4.Ears |  |  |
| 5.Nose |  |  |
| 6.Throat |  |  |
| 7.Teeth |  |  |
| 8.Gums |  |  |
| 9.Lymph Nodes |  |  |
| 10.Thyroid |  |  |
| 11.Lungs |  |  |
| 12.Heart |  |  |
| 13.Abdomen |  |  |
| 14.Musculoskeletal |  |  |
| 1. Neck |  |  |
| 1. Back |  |  |
| 1. Shoulders |  |  |
| 1. Knees |  |  |
| 1. Ankles |  |  |
| 1. Feet |  |  |
| 15.Extremedies |  |  |
| 16.Neurological |  |  |
| 18.Hearning Screening |  |  |
| 19.Mental Status |  |  |
| Any restrictions on your physical activity? | YES/NO |  |
| Any recommendations for medical care? | YES/NO |  |

**Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NOTE TO HEALTH CARE PROVIDER:**

All blanks must be filled in. If item not required (e.g. no Rubella titer because patient has been immunized) put N/A in that space to indicate you have checked that item. Copies of all lab results must be submitted with this form.

**REQUIRED IMMUNIZATION**

**Tdap Date: \_\_\_\_\_\_\_\_\_\_ MMR #1 Date: \_\_\_\_\_\_\_\_\_\_\_\_ MMR #2 Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Hepatitis B 1st Date: \_\_\_\_\_\_\_\_\_\_\_ 2nd Date: \_\_\_\_\_\_\_\_\_\_\_ 3rd Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Hepatitis B series may be complete while in the program and documentation of completion submitted.)

**LABORATORY RESULTS**

|  |  |  |
| --- | --- | --- |
| Hb Surf AB | Date: \_\_\_\_\_\_\_\_\_\_\_\_ | Positive/ Negative |
| Varicella Titer | Date: \_\_\_\_\_\_\_\_\_\_\_\_ | Immune/ Not Immune |
| Mumps Titer | Date: \_\_\_\_\_\_\_\_\_\_\_\_ | Immune/ Not Immune |
| Rubella Titer | Date: \_\_\_\_\_\_\_\_\_\_\_\_ | Immune/ Not Immune |
| Rubeola Titer | Date: \_\_\_\_\_\_\_\_\_\_\_\_ | Immune/ Not Immune |
| PPD (If PPD is positive, Chest X-Ray **or** Quantanferon Gold required) | Date: \_\_\_\_\_\_\_\_\_\_\_\_ | Positive/ Negative |
| Chest X-Ray | Date: \_\_\_\_\_\_\_\_\_\_\_\_ | Positive/ Negative |

Quantanferon Gold Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Positive/ Negative

**LICENSED HEALTH CARE PROFESSIONAL’S CERTIFICATION**

After careful review of the history, the physical finding and the result of the laboratory tests, I certify that this patient:

1. Has no communication diseases;
2. Has all required immunization or has proof of immunity through appropriate titer levels; and
3. Has no physical limitation, which impedes the unrestricted practice of direct patient care in a clinical setting.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of licensed health care professional Printed name of licensed health care professional*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Telephone number and extension Address*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date License (type and number)*

**Dental Hygiene Appointments**

1. **First Appointment- Registered Nurse (45 min)**

* PPD placement, Record Review. Bring any current physical exam (last 12 months). Also bring any proof of labs and/or immunizations.
* Dental Hygiene Labs (titers: Hepatitis B, Varicella, Mumps, Rubella, Rubeola).

1. **Second Appointment- Deanna McFadden, FNP/ Dr.Nugent (30 min)**

* PPD Read (Must be read within 48 to 72hrs from date and time applied)
* Physical Exam
* If required, the following vaccines will be administered at this appointment. (Tdap, Hepatitis B, MMR, (flu is optional).
* You will be provided a summary of charges applicable to you. These will be posted to your VCCCD account and payment must be submitted at OC Student Business Office or online.

**Appointments with:**

**Registered Nurse:** Monday and Tuesday 9am to 3pm

Friday 9am to 11pm

**Deanna McFadden, FNP:** Monday and Tuesday 9am to 12pm

Wednesday and Thursday 1pm to 5pm

**Dr. Nugent:** Tuesday and Wednesday 9am to 2pm

**\*\*\*Please note $10 no-show fee will be charged. Please call to reschedule or cancel 24 hours prior to appointment date.\***

**Oxnard College Student Health Center Fees**

|  |  |
| --- | --- |
| Hepatitis B titer | $8.00 |
| Varicella titer | $5.00 |
| Mumps titer | $13.00 |
| Rubella titer | $4.00 |
| Rubeola titer | $6.00 |
| PPD skin test (2step: $14) | $7.00 |
| Tdap vaccine | $35.00 |
| Hepatitis vaccine | $40.00 |
| Flu vaccine  Varicella vaccine | $20.00  $107.00 |
| MMR vaccine  Physical | $60.00  $20.00 |

**At the time of your appointment, we will evaluate what services are actually needed and the total fee will be determined.**

**If you have any other immunization records, please bring them to your appointment, otherwise in order to be cleared, vaccines will be administered.**

**DENTAL HYGIENE REQUIREMENTS CHECK LIST**

PPD Given\_\_\_\_/\_\_\_\_\_\_ Read \_\_\_\_/\_\_\_\_\_\_

**Titers:**

|  |  |  |
| --- | --- | --- |
|  | **Drawn** | **Results** |
| Hep B |  |  |
| Varicella |  |  |
| Rubeola |  |  |
| Mumps |  |  |
| Rubella |  |  |

**REQUIRED VACCINES Date Given**

|  |  |
| --- | --- |
| Tdap (current within 10 yrs.) |  |
| Flu (current Flu season) | Optional for this program. |

**Boosters (If Needed) Date Given/Waiver**

|  |  |
| --- | --- |
| Hep B |  |
| Varicella |  |
| Rubeola |  |
| Mumps |  |
| Rubella |  |
|  |  |
| Physical Exam Date Completed |  |
|  |  |