

Medical Clearance Form

To Examining Physician:

Huron College requires that all students registered in the dental hygiene program present this form to a qualified physician so as to provide third-party medical clearance. This form must be completed in order for the registered student to commence the program. Please complete the required sections provided below. Any previously completed immunization records may be attached to this form if appropriate.

A. General Patient Information

Full Name: _____ Student ID _____

Address: _____

Country of Birth: _____ Date of Birth: _____

B. Medical Examination

Date of Assessment: _____

Sensitivity to Latex? Yes No

If yes, please clearly explain the work restrictions: _____

IMMUNIZATION RECORD

Immunization record must be current in order for student to participate in the dental hygiene program.

	Immunization #1 (Date)	Immunization #2 (Date)
Measles		
Mumps		
Rubella		
Tetanus/ Diphtheria		
Polio		
Chickenpox		

IMMUNIZATION RECORD (continued)

Name: _____ Student ID# _____

Hepatitis B Antigen			
Serology	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date: _____
Hepatitis B			
#1 _____	#2 _____	#3 _____	
0	1 month	6 month	
Post Hep B Antibody			
Serology	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date: _____

Hepatitis C Antigen			
Serology	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date: _____
Hepatitis C			
#1 _____	#2 _____	#3 _____	
0	1 month	6 month	
Post Hep C Antibody			
Serology	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date: _____

Tuberculin skin Test*

	Result (mm)	Chest X-Ray <input type="checkbox"/> Yes <input type="checkbox"/> No
		(X-ray required only if TB test +)
Date: _____	_____	
Date: _____	_____	Date: _____
Date: _____	_____	

* Note: A baseline TB test is *only* required upon entry into your program of choice. Yearly testing not required.

Additional Immunization History:

Influenza	Date #1	Date #2	Date #3
Meningitis	Date #1	Date #2	Date #3
BCG	Date #1	Date #2	Date #3
Pneumonia	Date #1	Date #2	Date #3

Signature of Physician or Nurse Date

Original Released to Patient on: _____
Date

C. Medical Clearance

Full Name: _____ Student ID# _____

To be signed by the examining physician upon completion of the medical examination.

I, _____, of _____
(Please print) (Address)

have examined _____ and find her/him to be in good health and free of communicable disease.

Physician's Signature

Date Signed

Your assistance in this process is very much appreciated. Fees associated with the completion of this form and examination is the sole responsibility of the student. The student is also responsible for ensuring that this completed form is returned to Huron College.

(Please provide **the original** completed copy of this form to the student)

FACULTY OFFICE:

Copy of Medical Clearance Form provided to student Date:

Follow-up Required?

Yes No

Additional Comments: