Your Educational Partner of Choice BOCES 2 Center for Workforce Development

Dental Assisting - Medical Clearance Form

Student Name: _____ **DOB:** _____

Student Address: _____

Tel#: _____ **Email:** _____

Latex Allergy: Yes / No

Allergies: _____

Medication & Supplements (List All) ____ None

_____

Date: (within 6 months of class start date)	Height	Blood Pressure	Weight	Pulse

Please circle findings. Comment only if abnormal.

Hand/skin: normal / abnormal

Comment: _____

Head/eyes: normal / abnormal

Comment: _____

Ears/nose/throat/mouth: normal / abnormal

Comment: _____

Neck/nodes: normal / abnormal

Comment: _____

Chest/lungs: normal / abnormal

Comment: _____

Cardio/vascular: normal / abnormal

Comment: _____

Abdomen: normal / abnormal

Comment: _____

Musculoskeletal/extremity/spine: normal / abnormal

Comment: _____

Nervous system/seizure disorder: normal / abnormal

Comment: _____

Genito/urinary: normal / abnormal

Comment: _____

Name: _____ Program: _____

IMMUNIZATIONS: Please mark date of Vaccination & Lot number, or proof Titer

Administered Dates	#1	#2	#3	#4	Required or Optional?
HEP B Vaccine (series)	Date: Lot #	Date: Lot #	Date: Lot #	Date: Lot #	**Required**
MMR (Measles, Mumps, Rubella)	Date: Lot #	Date: Lot #			Optional (not having these vaccines may limit your internship site options)
Sars-Cov-2 Vaccine	Date: Lot #	Date: Lot #	Date: Lot #	Date: Lot #	
Influenza Vaccine (seasonal)	Date: Lot #				
PPD SKIN TEST Date Placed :	Date Read:	Read By :	Lot Number #	Results:	

Positive PPD, chest X-ray results: _____ Date: _____

Result (circle one): Normal / Abnormal (Mo/Day/Yr.)

Does this patient suffer from any chronic physical or mental disabilities and or limitations that would interfere with patient care for a period of 6 hour to 12 hour working days?

YES or NO**, if YES, please explain**:

_____

_____

To the best of my knowledge the above-named patient has been medically cleared to participate in clinical work and/or education at this time.

Physician's Name: _____
Print ***Date***

Physician's Signature: _____
Sign ***Date***

Physician's Office Stamp:

Instructions for Completing the Medical Clearance Form

For ALL students taking the BOCES 2/CWD Adult Education Dental Assisting Program

It is a **New York State mandate** that in order for you to participate in either of these programs, the attached medical form must be completed and submitted.

Below are the steps that will assist you with completing this form prior to enrollment.

1. Please have the Medical Clearance Form completed by a physician.
    - Students without a primary care physician may be able to complete the form through an urgent care facility, such as WellNow Urgent Care Clinic at 2232 Lyell Ave, 585-417-4125.

2. **ALL** fields must be filled out **by your doctor(s)** prior to entering into the "clinical" portion of either program.

3. The medical form **must be signed**, **dated and stamped by your doctor(s) in order for BOCES 2 CWD to accept the document.**

4. It is **recommended** that you pick up the original medical form from your doctor(s) and make a copy for your records.

5. It is **recommended** that you drop off the medical form to the BOCES 2 Center for Workforce Development Main Campus office located at 3555 Buffalo Road, Rochester NY 14624. **You may have your physician fax it with your proper consent to: (585) 349-9101 Attention: Admissions**

Please note that it is YOUR RESPONSIBILITY to ensure that this medical form is completely filled out, signed, dated, and stamped by your doctor and turned in to the BOCES 2/CWD office.

*** If you unable to get this form completed by your doctor before the start of your program, A Medical Clearance Confirmation Form MUST be completed which will confirm that an appointment has been made. ***

If you have any questions, please do not hesitate to call us at (585) 349-9100 for assistance.

Revised 8/8/2022

Medical Clearance Confirmation Form

Student Name: _____

Program: _____ Start Date: _____

This form certifies that you have acquired a doctor's appointment to have your medical clearance form completed.

Date of Appointment: _____

Time: _____

Physician: _____

Please attached proof from your doctor's office with confirmation of appointment.

Client Signature: _____ Date: _____

By completing this form, you understand that your medical clearance form must be completed, with all requirements fulfilled, within **30 days of this form or you will be ineligible to participate in clinical and complete your program to receive your certificate of completion.**