MIDDLESEX COMMUNITY COLLEGE

DENTAL HYGIENE LOCAL ANESTHESIA COURSE PARTICIPANT INFORMED CONSENT STATEMENT

I, the undersigned, hereby acknowledge that I have voluntarily agreed to participate in the Dental Hygiene Local Anesthesia Certification program at Middlesex Community College. I have completely and accurately revealed and described my previous and current medical and dental conditions on my health history form, which is hereby incorporated by reference.

Upon Registration for the lecture and clinical practice course in local anesthesia I understand I will be administering and receiving injections as a condition of course completion. The injections will take place in the Dental Hygiene lab at MCC with direct faculty supervision and according to applicable laws, regulations and safety standards. I understand that if I am pregnant, breast feeding, or have other health concerns *(ie: high blood pressure, allergies to local anesthetic, or oral lesions)* that will not exclude me from participating in the training, but will preclude me from receiving injections of anesthetics, I will provide a substitute over the age of 18 to serve as a patient to receive injections on my behalf. If I require a substitute, I will notify Middlesex Community College prior to the clinical training and my substitute will be required to provide a medical history.

As with all dental hygiene treatment, I know there is a possibility that I may experience discomfort. I also understand that there are certain risks entailed in any injection of local anesthetic including but not limited to local complications such as: trismus, hematoma, transient paresthesia and facial nerve paralysis. I am willing to undertake the risk of giving and receiving these injections.

I hereby knowingly, freely, and voluntarily release and hold harmless the Commonwealth of Massachusetts, Higher Education Coordinating Council, Middlesex Community College and their agents, employees, servants, students and assignees from any and all liability, claims, demands or causes of action whatsoever, including liability for negligence, arising out of any damage or injury which I might suffer in the course of, or related to, participation in the Dental Hygiene Local Anesthesia Certification Training Program at Middlesex Community College.

Student Name (print) _____

Student Signature _____ Date _____

If applicable

Patient Substitute Name (print)_____

Patient Signature _____ Date _____

MEDICAL HISTORY

Please print in black or blue ink

Name_____ Mr. Mrs. Ms. Date of Birth _____
Last First MI **Please circle**

Address _____
Street City State Zip code

Home phone # Cell phone # Email Occupation

Emergency Contact Relationship Telephone

Physician's Name Address Telephone

Dentist's Name Address Telephone

If you are completing this form for another person, what is your name and your relationship to this person?

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*For the following questions, circle **yes** or **no**, whichever applies. Your answers are for our records only and will be considered **confidential**. Please note that you may be asked some questions about your responses and there may be additional questions concerning your health.*

1. Has there been any change in your general health within the past year? yes no
2. Date of last physical exam _____
3. Are you now under the care of a physician? yes no
   If so, what is the condition being treated? _____
4. Have you had any serious illness, operation or been hospitalized? yes no
   If so, what was the illness or problem? _____
5. Are you taking or have you recently taken any prescription or over the counter medicines? yes no

Please list all, including prescriptions, vitamins, natural or herbal preparations and/or diet supplements, including dosages (if known) _____

6. Do you have or have you had any of the following diseases or conditions: Comments
   a. Damaged heart valves or artificial heart valves no yes _____
   b. Rheumatic fever or rheumatic heart disease no yes _____
   c. Congenital heart problems no yes _____
   d. Heart murmur or mitral valve prolapse no yes _____
   e. Cardiovascular disease (heart trouble, heart attack, angina, stroke, high blood pressure, coronary artery disease no yes _____
   f. Do you have a cardiac pacemaker? no yes _____
   g. Allergy, hives, skin rash, or hay fever no yes _____
   h. Asthma no yes _____
   i. Fainting spells or episodes of unconsciousness no yes _____
   j. Epilepsy or other neurological disorders no yes _____
   k. Diabetes no yes _____
      If so, what type? _____
      Is there a history of diabetes in your family? no yes _____
      If so, what is their relationship to you? _____
   l. Hepatitis or liver disorder no yes _____

m. Persistent diarrhea or recent weight loss no yes _____
n. HIV positive, AIDS, or other immune system problems no yes _____
o. Thyroid problems. no yes _____
p. Respiratory problems, emphysema, bronchitis, etc. no yes _____
q. Tuberculosis no yes _____
r. Persistent cough or cough that produces blood no yes _____
s. Arthritis, painful joints or osteoporosis no yes _____
t. Joint replacement no yes _____
u. Stomach ulcers, esophageal reflux, inflammatory bowel disorder no yes _____
v. Kidney disease or renal dialysis treatment no yes _____
w. Persistent swollen glands, mononucleosis, chronic fatigue syndrome no yes _____
x. Low blood pressure no yes _____
y. Sexually transmitted disease . no yes _____
z. Mental health disorders (anxiety, depression, ADD, etc.) no yes _____
aa. Alcohol or drug use no yes _____
bb. Eating disorders no yes _____
cc. Cancer no yes _____
dd. Radiation therapy or chemotherapy no yes _____
ee. Treatment for a tumor or growth no yes _____
ff. Blood disorder (such as anemia, hemophilia, leukemia) no yes _____
If so, how is it treated? _____
gg. Abnormal bleeding or bruising no yes _____
hh. Previous blood transfusions no yes _____
ii. Recurrent cold sores or fever blisters no yes _____
jj. Human Papilloma Virus (HPV) no yes_ _____

7. Do you use any tobacco or nicotine products? no yes _____
8. Have you ever taken appetite suppressants? (e.g. Fenphen, Redux) no yes _____
9. Have you been treated with cortisone or steroids in the last 2 years? no yes _____
10. Do you use marijuana? no yes _____
11. Are you allergic or have you ever reacted to:
    a. Local anesthetics no yes _____
    b. Penicillin or other antibiotics no yes _____
    c. Sulfa drugs no yes _____
    d. Aspirin or other medicines for pain no yes _____
    e. Iodine or shellfish products no yes _____
    f. Latex products no yes _____
    g. Dyes no yes _____
    h. Bisulfites or sulfite agents no yes _____
    i. Any drugs, food, or other substance not listed above no yes _____
12. Do you have any disease, condition, or problem not listed above that you think we should know about? no yes_____
    If yes, please explain _____
13. What is your current height? _____ft_____in
14. What is your current weight? _____lbs

Female Patients Only

15. Are you pregnant? (If yes, trimester_____) no yes _____
16. Are you nursing? no yes _____
17. Do you have any problems associated with your menstrual period? no yes _____
18. Do you take oral contraceptives or other hormonal therapy? no yes _____

DENTAL HISTORY

1. Date of last dental exam in a dental office and what was done? _____

2. Date of last dental hygiene appointment _____

3. Date of last dental x-rays and type, if known _____

4. Have you ever had any of the following:			Comments
a. orthodontic treatment	no	yes	
b. periodontal treatment	no	yes	
c. oral surgery or extractions	no	yes	
d. endodontic treatment or root canals	no	yes	
e. prosthodontic treatment (crowns/bridgework)	no	yes	
f. dental implants	no	yes	
g. facial trauma	no	yes	
h. cosmetic procedure to face or lips	no	yes	
i. treatment for TMJ problems	no	yes	
5. Have you had any serious trouble associated with any previous dental treatment?	no	yes	
If yes, please explain			
6. Are you ever anxious or uncomfortable about having dental treatment?	no	yes	
7. Are you wearing any removable dental appliances?	no	yes	
8. Do you frequently have a dry mouth?	no	yes	
9. Do you currently have any dental or mouth pain?	no	yes	
If yes, please explain			
10. Do your gums bleed when you brush or floss?	no	yes	
11. Do you have sensitive teeth?	no	yes	
12. Do you ever have canker sores or cold sores?	no	yes	
13. Do you have problems with food getting trapped between your teeth?	no	yes	
14. Is it difficult for you to open your mouth wide?	no	yes	
15. Does your jaw click or have pain upon opening?	no	yes	
16. Do you clench or grind your teeth?	no	yes	
17. Do you wear a nightguard or a retainer?	no	yes	
18. Do you gag easily?	no	yes	
19. Type of toothbrush used – soft, medium, hard, electric			

20. How often do you:
    a. brush your teeth _____
    b. use dental floss _____

To the best of my knowledge, the above medical history is accurate and has been completed by me.

For clinic use only:

_____
Patient/parent/guardian signature Date Student signature

___/___	_____	_____	_____	_____
Blood Pressure	Pulse	Respiration	BMI	ASA Classification

_____
Instructor Signature

Medical Consult required? No Yes Reason _____

Revised June 2018