The Ohio State University College of Dentistry Continuing Dental Education
Dental Hygiene Local Anesthesia Course Substitute Participant
Informed Consent and Release Statement

I, the undersigned, hereby acknowledge that I have voluntarily agreed to participate in the Dental Hygiene Local Anesthesia Certification Continuing Education program at The Ohio State University College of Dentistry (OSU CoD). 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 combined academic and practical course on local anesthesia, I understand I will be receiving intraoral local anesthetic injections as a condition of course completion. The injections will take place in the clinical facilities at OSU CoD with direct faculty supervision and according to applicable laws, regulations and safety standards. I understand that if I have any of several health conditions that may preclude me from receiving local anesthetic solutions or injections, e.g. high blood pressure, allergies to local anesthetic solutions, oral lesions, or am pregnant or breast-feeding, etc., these may preclude me from receiving injections or the injection of local anesthetic solutions.

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 anesthetics including, but not limited to, 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 Ohio State University College of Dentistry 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 CE Program at The Ohio State College of Dentistry.

Substitute Participant Name (print)_________________________________

Substitute Participant Signature____________________________________ Date __________________
Patient Name: ____________________________ Today’s Date: __________________
(First)             (Last)

MEDICAL HISTORY:
Do you have, or have you had any of the following?
Circle One

1. High Blood Pressure Y N
2. Angina / Chest Pain Y N
3. Cardiac Pacemaker Y N
4. Heart Attack Y N
5. Heart Disease Y N
6. Heart Murmurs / Mitral Valve Prolapse Y N
7. Stroke Y N
8. Fainting / Seizures Y N
9. Respiratory / Lung Condition Y N
10. Shortness of Breath Y N
11. Radiation Therapy Y N
12. Cancer Y N
13. Do you have any bone diseases? Y N
   (Osteoporosis, Paget’s disease, Cancer with Spread to the bones breast, lung, liver, prostate, or kidney)
   Multiple Myeloma or other bone conditions? Y N
14. Are you taking any Bisphosphonate Medications? Y N
15. Tuberculosis Y N
16. Thyroid Problems Y N
17. Immune Disorder / HIV Y N
18. Glaucoma Y N
19. Diabetes Y N
20. Kidney Disease Y N
21. Liver Disease / Hepatitis Y N
22. Stomach Problems Y N
23. Arthritis Y N
24. Recent Weight Gain or Loss? Y N
25. Joint Replacement or Prosthetic Implant Y N
26. Are you currently nursing or pregnant? Y N
27. Allergies to medications or latex? Y N
   (Please list)________
28. Use tobacco products Y N
29. Have you taken any diet medications or products? Y N
30. Prolonged bleeding Y N
31. Hearing problems / hearing aids Y N
32. Date of Last Medical Exam ____________________________
33. Do you have or have you ever had any disease, condition or problem not listed here? Y N
34. Have you ever been told you need to take an antibiotic prior to dental treatment? Y N
35. Are you currently under the care of a physician (M.D., D.O.)? Y N
36. Have you had trouble associated with previous dental treatment? Y N
37. When was your last dental check-up and/or cleaning? ____________________________
38. Are you currently taking any drugs, medications, or supplements? Please list below Y N
   (Medications such as antibiotics, heart medicine, birth control pills, aspirin therapy, vitamins, herbal supplements)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose/ Frequency</th>
<th>Reason for Taking</th>
</tr>
</thead>
<tbody>
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I certify that the above information is complete and accurate to the best of my knowledge:

Signature: ____________________________ Relationship to Patient: Self Parent Guardian

To be completed by your dentist- Summary of Patient’s Medical Status:

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Dentist’s Signature: ____________________________ Date: __________________

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In Case of Emergency, Please Notify

Name:______________________________________________
Relationship:_________________________________________
Home Phone:______________________
Cell Phone:________________________
Work/Other Phone:__________________
Address:_____________________________________________
City:________________________________________________
State:______________   Zip:_______________
## LOCAL ANESTHESIA FOR THE DENTAL HYGIENIST

### IMMUNIZATION / HEALTH & SAFETY TESTING REQUIREMENTS

**PLEASE PROVIDE DOCUMENTATION FOR PROOF OF THE FOLLOWING**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Documentation Required</th>
<th>Date</th>
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<tbody>
<tr>
<td><strong>INFLUENZA VACCINATION - annual</strong></td>
<td>Proof of vaccination (current)</td>
<td>/ /</td>
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<tr>
<td><strong>TB SKIN TEST / PPD (2-step)</strong></td>
<td>Current (within one year) negative tuberculin skin test (Mantoux) or, if positive history, a negative x-ray.</td>
<td>/ /</td>
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<tr>
<td><strong>PPD Test 1</strong></td>
<td>Date</td>
<td>/ /</td>
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<tr>
<td><strong>PPD Test 2</strong></td>
<td>Date</td>
<td>/ /</td>
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<tr>
<td><strong>TDAP</strong></td>
<td>Proof of vaccination (within 10 years)</td>
<td>/ /</td>
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<tr>
<td><strong>HEPATITIS B SERIES (3 DOSES IN 6 MONTHS) OR</strong></td>
<td>Copy of vaccination series or titer (surface antibody test)</td>
<td>/ /</td>
</tr>
<tr>
<td><strong>HEP B- DOSE 1</strong></td>
<td>Date</td>
<td>/ /</td>
</tr>
<tr>
<td><strong>HEP B- DOSE 2</strong></td>
<td>Date</td>
<td>/ /</td>
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<tr>
<td><strong>HEP B- DOSE 3</strong></td>
<td>Date</td>
<td>/ /</td>
</tr>
<tr>
<td><strong>HEP B Surface Antibody Test</strong></td>
<td>Copy of results</td>
<td>/ /</td>
</tr>
<tr>
<td><strong>MMR (measles, mumps, rubella )</strong></td>
<td>Proof of vaccination (or copy of results of titer)</td>
<td>/ /</td>
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<tr>
<td><strong>MMR DOSE 1</strong></td>
<td>Date</td>
<td>/ /</td>
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<tr>
<td><strong>MMR DOSE 2</strong></td>
<td>Date</td>
<td>/ /</td>
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<tr>
<td><strong>Titer</strong></td>
<td>Date</td>
<td>/ /</td>
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<tr>
<td><strong>CHICKENPOX</strong></td>
<td>Proof of vaccination (or copy of results of titer)</td>
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<tr>
<td><strong>VARICELLA DOSE 1</strong></td>
<td>Date</td>
<td>/ /</td>
</tr>
<tr>
<td><strong>VARICELLA DOSE 2</strong></td>
<td>Date</td>
<td>/ /</td>
</tr>
<tr>
<td><strong>Titer</strong></td>
<td>Date</td>
<td>/ /</td>
</tr>
<tr>
<td><strong>CPR FOR HEALTHCARE PROVIDERS CERTIFICATION</strong></td>
<td>Copy of current card (front and back) - CPR for healthcare providers certification must be from the American Heart Association, the American Red Cross, or the American Health and Safety Institute. Cards from any other entity will not be accepted.</td>
<td>/ /</td>
</tr>
<tr>
<td><strong>DENTAL HYGIENE LICENSE</strong></td>
<td>Copy of current Ohio license (front and back)</td>
<td>/ /</td>
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</tbody>
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### ONLINE TRAINING SESSIONS

**PLEASE PRINT A COPY OF ALL TRAINING MODULE COMPLETION PAGES TO SUBMIT TO THE CE OFFICE**

<table>
<thead>
<tr>
<th>Training</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIPAA Modules &amp; Test</strong></td>
<td><a href="http://www.dent.ohio-state.edu/hipaa/">http://www.dent.ohio-state.edu/hipaa/</a></td>
</tr>
</tbody>
</table>

Please send this form along with proof of immunization and training module completion to
the Continuing Dental Education Office
Fax: 614-688-3188 or Email: osucde@osu.edu