



Dental Hygiene Student Name _____

Office
Use
Only

Please complete the information requested below and return this form, your completed Health Assessment form, and copies of your CPR and health insurance cards to the RCTC Allied Health Office, located at HC 205.

◆ **Insurance Signature:** My signature below indicates that I understand that personal health insurance coverage is a requirement of the RCTC Dental Hygiene Program. I am currently covered by a health insurance plan and I understand that I am required to maintain coverage while I am a student in this program. I have provided the RCTC Allied Health office a copy of my health insurance information and I agree to notify this office if my coverage changes.

Student Signature _____ Date _____

◆ **Health Assessment:** _____ (completed Health Assessment form required)

◆ **Tetanus/Diphtheria:** _____

◆ **Chicken Pox (Varicella):** Had Disease? Yes _____ No _____

If no, date of vaccination: 1st _____ 2nd _____

Or date of titer: _____ Result _____

◆ **Measles, Mumps, and Rubella (MMR):** 1st _____ 2nd _____

◆ **Hepatitis B:** 1st _____ 2nd _____ 3rd _____

◆ **CPR:** Expiration Date: _____ (copy of current card required)

◆ **TB Skin Test (TST, Mantoux):** Most recent date _____ Result _____

Complete this section only if history of a positive TST:

Date of most recent Chest X-ray _____ Findings _____

Prophylactic Treatment? Yes _____ No _____

If yes, date started _____ *date completed* _____

Is there any additional information about your physical or psychological health that would be helpful for us to know in case of an emergency, (i.e., diabetes, epilepsy, allergies, etc.)?

I understand that providing false information on this document can result in expulsion from the program. By signing this form, I verify that the above information is correct.

Student Signature _____ **Date** _____

Immunization and Other Requirements for Dental Hygiene Students

Measles (Red Measles, Rubeola)

If born before 1957:

- Date of one measles or MMR vaccine **or**
- Physician diagnosis of disease **or**
- Report of immune titer proving immunity

If born in or after 1957:

- Physician diagnosis of disease **or**
- Dates of two doses of measles or MMR vaccine after one year of age **or**
- Report of immune titer proving immunity

Mumps

- Date of one mumps or MMR vaccine **or**
- History of disease

Rubella (German Measles)

- Date of one rubella or MMR vaccine **or**
- Report of immune titer proving immunity
Note: History of disease is not accepted.

Tetanus/Diphtheria

- Date of booster vaccination within the last 10 years, REGARDLESS OF DATE OF BIRTH

Hepatitis B

- Date(s) of vaccination. (The Hepatitis B vaccine is given in a series of three doses. At minimum, this series must be started before beginning clinical experience.) **or**
- Report of positive antibody (if secondary to disease)

Tuberculin Test (Mantoux)

- Date and result of test within six months prior to beginning clinical experience and every 12 months after that while enrolled in the Dental Hygiene Program. If the test is positive, the individual must have a report of a negative chest x-ray within six months prior to beginning clinical experience and complete a TB questionnaire annually.

Annual Flu Shot

- While not required, it is highly recommended that student receive the flu shot annually.

Chicken Pox (Varicella)

- History of disease **or**
- History of positive titer

Physical Exam

- Dental Hygiene Student Health Assessment form completed and signed by health care provider within one year prior to beginning the Dental Hygiene Program.

Health Insurance

- Documentation of personal coverage including company name and policy numbers.

CPR

- Documentation of current Professional Rescuer Certification.

STUDENT: Complete this section before giving to healthcare provider.

Student's Name _____

Student's RCTC Stinger ID # _____

HEALTHCARE PROVIDER: Please complete this section.

Based on this student's health history and this assessment, it is my judgment that this student:

*(Check the statement that best applies. *Essential Requirements on page 2)*

Is able to physically and emotionally perform the essential requirements* of his/her educational experience.

Is able to physically and emotionally perform the essential requirements* of his/her educational experience with the following restrictions:

Is unable to physically and emotionally perform the essential requirements* of his/her educational experience.

Additional Comments or Concerns:

Healthcare provider's stamp or printed name: _____

Signature: _____ Date: _____

Address: _____

Telephone: _____

Essential Requirements for a Dental Hygienist

1. **Ability to think critically**

Examples: Make clinical decisions during patient treatment; respond to changes in the patient's condition; follow clinical protocols for infection control and hazards management; work independently, problem solve, respond in emergency situations.

2. **Ability to demonstrate fine motor skills.**

Examples: Perform clinical procedures in the mouth with hand and mechanical instruments; operate technical equipment.

3. **Ability to demonstrate effective interpersonal skills**

Examples: Interact with patients, families, staff, and groups from a variety of social, emotional, cultural, and intellectual backgrounds.

4. **Ability to see well**

Examples: Inspect and assess dental/oral conditions, perform clinical procedures with hand and mechanical instruments in the mouth, observe healthy and unhealthy tissue detail in the oral cavity.

5. **Ability to hear well**

Examples: Respond to the patient's needs during dental treatment; hear and assess patient breath and heart sounds; respond to emergency signals.

6. **Ability to function effectively and efficiently in a healthcare setting**

Examples: Can think and move fast; adaptable and flexible; maintains professional demeanor; can remain calm and composed during stressful situations.

7. **Ability to have tactile capabilities**

Examples: Successfully perform palpation; note changes in skin temperature; perform instrumentation and dental procedures wearing exam gloves; use computers.

8. **Ability to maneuver in small spaces**

Examples: Access dental treatment areas; function as an operator or assistant in the dental treatment room; move into, around, and out of work spaces; procure emergency equipment.

Information for Students with Disabilities

The American with Disabilities Act (ADA) of 1990 was instituted by Congress to prohibit discrimination against qualified individuals with disabilities. RCTC, like other state and federally funded entities, are required to comply with the stipulations of the ADA. The ADA defines a qualified individual with a disability as an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires. In addition, the Rehabilitation Act of 1973 prohibits discrimination in admissions of a qualified person with disabilities.

ADA and the Rehabilitation Act of 1973 eligibility requirements vary depending on the type of services, activities, and functions needed in particular areas. The dental assisting field is an applied discipline with cognitive, sensory, affective and motor components. Students must be able to perform the functions which are necessary for the safe practice of dental assisting. These are essential with or without reasonable accommodations in order to be admitted to the Dental Hygiene Program at Rochester Community and Technical College.

If a student requires disability accommodations, he/she must self identify and provide appropriate documentation directly to RCTC Disability Support Services. It is **strongly recommended** that the student do this prior to beginning the Dental Assisting Program. RCTC Disability Support Services is located in the University Center Rochester in the Student Support Services Office, SS172. The phone numbers are: (507) 280-2968 and the Minnesota relay TTY 1-800-627-3529 or e-mail travis.kromminga@roch.edu.