**Admission Criteria**

Students interested in the LCC Dental Assisting Program are admitted to the college on the same basis as other students, but admission to the college does not ensure admission into the Dental Assisting Program. The selection process for the Dental Assisting Program is competitive and based on the following factors:

- High school graduate or equivalent
- COMPASS reading score higher than 75 or ACT score of 17 or above
- TEAS assessment test
- Three (3) references, one of which should be a current or former employer
- Application essay questions (in your own handwriting)
- Observation hours clinician rating sheets
- Interview with the selection committee

Submit to a criminal background check (information page included in application packet)

<table>
<thead>
<tr>
<th><strong>Offer of acceptance contingent upon—</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>satisfactory physical evaluation, verified by a physician that includes immunization records; 2-step TB skin test; and CPR certification (for healthcare providers).</td>
</tr>
</tbody>
</table>

**DANB-Accepted CPR, BLS and ACLS Providers**

Students seeking the Associate in Applied Science Dental Assistant Program Degree may complete general education courses that satisfy the program requirements prior to acceptance (with a minimum GPA of 2.5) or after completion of the program.

If you are not a previous LCC student, you will need to apply to LCC online.

### The Dental Assisting Program

begins in August of each year.

### APPLICATION CHECKLIST

**Before JULY 8, 2019**

Verify official high school/college transcript(s) are in the LCC Admissions Office.

**Before JULY 8, 2019**

- Deliver forms to your references; verify they are on file in DA Program Office.
- Email sherrys@labette.edu to schedule and take the TEAS exam.
- Complete observation hours; verify paperwork is on file in DA Program Office
- Complete background check online at: www.mystudentcheck.com
- Deliver completed application packet to LCC DA Program Office at Cherokee Center or mail to Labette Community College, Attn: Leigh Ann Martin, 200 S 14th St., Parsons, KS 67357 by 7/8/19.

For questions about the program, contact Leigh Ann Martin, DA Program Director, at 620-232-5820 or leighannm@labette.edu.

**TEAS V**

http://www.labette.edu/dental/assets/TEAS-Exam-Test-Dates.pdf

Create your account (use the “Labette ADN program” tab).

The TEAS V Study Guide is available for purchase at www.atitesting.com or the LCC Bookstore.

### TO COMPLY WITH THE FAMILY EDUCATION RIGHTS AND PRIVACY ACT OF 1974 (FERPA)

No copies from the student file will be released once received in the DA Program Office. Students should keep copies of all materials submitted to the program for their personal education records.

The LCC Dental Assistant Program is accredited by the Commission on Dental Accreditation. The Commission is a specialized body recognized by the United States Department of Education. The Commission on Dental Accreditation can be contacted at (312) 440-4653 or at 211 East Chicago Avenue, Chicago, IL 60611.

The Commission's web address is: http://www.ada.org/100.aspx
Dear Dentist/Dental Assistant:

One of the prerequisites for consideration for admission to the Dental Assistant Program at Labette Community College is observation of a minimum of 16 hours of restorative procedures (not hygiene procedures) in a dental practice under the observation of a dentist or dental assistant. Please complete this form, place in an envelope, initial the seal, and send it to the address below. Upon completion of the observation the applicant should be able to give rationale for why he/she wants to become a Dental Assistant.

APPLICANT NAME: _________________________________________________________  DATE: ______________________

FACILITY OBSERVED: ___________________________________________________________

TYPE OF FACILITY: _____________________________________________________________________________

ADDRESS OF FACILITY: ____________________________________________________________________________

Please consider the following and provide your overall impression of the applicant--

- Arrived promptly for observation and stayed the agreed upon amount of time.
- Was neat & appropriate in their appearance and behavior.
- Showed effective listening skills & good verbal communication.
- Observed attentively and with interest.
- Showed confidence & enthusiasm through their behavior.
- Asked questions/gave comments that indicated an attempt to learn about the field of Dentistry.

Please circle the number that represents your overall impression of this applicant.

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<thead>
<tr>
<th>EXCELLENT</th>
<th>GOOD</th>
<th>SATISFACTORY</th>
<th>FAIR</th>
<th>POOR</th>
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<td>15</td>
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<td>13</td>
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<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

COMMENTS: __________________________________________

The student waives all rights to view the completed observation documents by signing here:

___________________________________________  _____________________  _____________________
Student Signature  Date  LCC ID# or SS#

Amount of time observed: ________________  Date(s) of observation: ______________________________________

CLINICIAN SIGNATURE: ___________________________________________________________________________  DATE: _________________

PRINTED CLINICIAN NAME: ______________________________________  PHONE: __________________

The clinician who was observed should complete and return this form to:
Leigh Ann Martin, DA Program Director, Labette Community College, 200 S. 14th St., Parsons, KS 67357.

THANK YOU FOR YOUR TIME AND COOPERATION WITH THIS PROCESS—LCC DA Program Staff
I, the undersigned, as a prospective student of the Dental Assisting Program at Labette Community College, understand that I am assigned to _________________________________ for

(Observation Facility)

observation and that all information concerning patients is to be treated as “confidential”. Patient information is NOT to be discussed with anyone outside the confines of the dental practice/clinic.

I understand that disregard for the above statements or any violation on my part will jeopardize my acceptance into the Labette Community College Dental Assisting Program.

_________________________________________  ______________________
Applicant Signature  Date
DENTAL ASSISTING PROGRAM
Prospective Dental Assisting Student Reference Form

Applicant’s Name  

(please print)

I, _______________________________________________, (DA Program applicant), waive my right to view this reference form.

This reference is confidential. On a scale of one to five, with one (1) being the lowest possible rating and five (5) being the highest, please rate the applicant named above. If you cannot rate the applicant in all areas, please notify them so they can name another reference. Place this form in an envelope, seal the envelope, initial the seal and return/mail to Leigh Ann Martin, DA Program Director, Labette Community College, 200 South 14th Street, Parsons, KS 67357.

<table>
<thead>
<tr>
<th>PERSONAL QUALITIES</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Appearance</td>
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<tr>
<td>Cooperation</td>
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<td>Dependability</td>
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<td>Emotional Control</td>
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<td>Honesty</td>
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<td>Judgment</td>
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<td>Punctuality</td>
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<td>Flexibility</td>
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<td>Initiative/Motivation</td>
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<td>Leadership</td>
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<tr>
<td>Organizational Skills</td>
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</tbody>
</table>

Your relationship to the applicant: [ ] Employer [ ] Co-Worker [ ] Teacher [ ] Other

(Family member references will not be accepted.) If “Other”, please identify relationship—

1. Would you endorse this applicant as a candidate for a health care career? yes no
2. If you had the opportunity to employ this individual, would you do so? yes no
3. Any additional comments about the applicant:

Please Print Name: ___________________________________________ Date: __________

Signature: ___________________________________________ Phone #: ______

Title/Occupation: ___________________________________________

Address: ___________________________________________

Street City State Zip
Applicant’s Name ________________________________________________ (please print)

I, _______________________________________________ (DA Program applicant), waive my right to view this reference form.

This reference is confidential. On a scale of one to five, with one (1) being the lowest possible rating and five (5) being the highest, please rate the applicant named above. If you cannot rate the applicant in all areas, please notify them so they can name another reference. Place this form in an envelope, seal the envelope, initial the seal and return/mail to Leigh Ann Martin, DA Program Director, Labette Community College, 200 South 14th Street, Parsons, KS 67357.

<table>
<thead>
<tr>
<th>Poor</th>
<th>Average</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Your relationship to the applicant:  

□ Employer  □ Co-Worker  □ Teacher  □ Other  

(Family member references will not be accepted.) If “Other”, please identify relationship—

1. Would you endorse this applicant as a candidate for a health care career?  
   □ Yes  □ No

2. If you had the opportunity to employ this individual, would you do so?  
   □ Yes  □ No

3. Any additional comments about the applicant:

Please Print Name: ____________________________________________ Date: ________________

Signature: ____________________________________________ Phone #: ________________

Title/Occupation: ____________________________________________

Address: ____________________________________________

Street  City  State  Zip
**Prospective Dental Assisting Student Reference Form**

Applicant’s Name ____________________________________________________________

(please print)

I, ________________________________________________________________, (DA Program applicant), waive my right to view this reference form. This reference is confidential. On a scale of one to five, with one (1) being the lowest possible rating and five (5) being the highest, please rate the applicant named above. If you cannot rate the applicant in all areas, please notify them so they can name another reference. Place this form in an envelope, seal the envelope, initial the seal and return/mail to Leigh Ann Martin, DA Program Director, Labette Community College, 200 South 14th Street, Parsons, KS 67357.

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</tbody>
</table>

Your relationship to the applicant:  

- [ ] Employer  
- [ ] Co-Worker  
- [ ] Teacher  
- [ ] Other  

(Family member references will not be accepted.)  

If “Other”, please identify relationship—______________________________

1. Would you endorse this applicant as a candidate for a health care career?  
   - [ ] Yes  
   - [ ] No

2. If you had the opportunity to employ this individual, would you do so?  
   - [ ] Yes  
   - [ ] No

3. Any additional comments about the applicant:

Please Print Name: ________________________________ Date: ________________

Signature: ____________________________________________________________ Phone #: ________________________________

Title/Occupation: __________________________________________________________

Address: ____________________________________________ Street City State Zip
General guidelines for a successful clinical observation experience:

Business casual attire is required—
- Khaki pants (clean and pressed); shirt or blouse (clean and pressed); closed toe shoes (clean)
- No jeans, ripped clothing, open toe shoes, shorts, hats or shirts with writing on them
- All clothing must fit properly without exposure of any inappropriate body part (even when bending over)
- Demonstrate good hygiene practices with long hair pulled back and well groomed facial hair
- Cover tattoos and remove piercings
- Conservative earrings/jewelry

Courtesy to the staff is required—
- You are a guest in their facility, act accordingly
- Be engaged in the process
- No cell phone usage during observation hours
- Be on time
- Display a positive attitude
- Ask questions in a sensitive manner
- Provide an envelope with the Dental Assistant Program’s address and place appropriate postage on the envelope
- Thank the staff for their time
**DENTAL ASSISTING PROGRAM**  
Application (p.1)

Name _____________________________________________________  SS# _________________________  LCC Student ID# ____________

Any other last names used ______________________________________  Home Phone _______________

Mailing _________________________________________________________  Cell Phone _______________

Address Street/P.O. Box City State Zip  Work Phone _______________

Physical _________________________________________________________  Date of Birth __________

Address Street/P.O. Box City State Zip

E-Mail Address ________________________________________________  Male   Female

U.S. Citizen Yes No  County of Residence _______________________

Ethnic Background: Native American African American Asian American Caucasian American International Other

Next of kin or for emergency notification: Name ___________________________ Relationship ____________________  Phone _______________

Address Street City State Zip

Employed by ___________________________________________  Phone _______________

EDUCATIONAL BACKGROUND

Are you a high school graduate? Yes No  If yes, year graduated __________

If no, do you have a high school equivalent (GED)? Yes No  If yes, year graduated __________

Have you ever attended or applied to any DA program? Yes No  If yes, give name and location of school: ______________________________

Dates attended: ___________________________  Reason for leaving: ___________________________

**************************************************************

High School:  _______________________________________________________________________

**************************************************************

College (s):  _______________________________________________________________________

**************************************************************

Degrees Earned:  _____________________________________________________________________

**************************************************************

**FOR AAS BOUND STUDENTS ONLY**  
Please indicate the year, grade and college of the following courses you have completed or mark an X in the “Currently Taking” box.

<table>
<thead>
<tr>
<th>Course</th>
<th>Year</th>
<th>Grade</th>
<th>Currently Taking</th>
<th>College Initials</th>
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<tr>
<td>A &amp; P (with lab)</td>
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<tr>
<td>English Comp I</td>
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<tr>
<td>Fund. of Speech</td>
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<tr>
<td>Applied Math OR Int. Algebra</td>
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<tr>
<td>Gen. Psychology</td>
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<tr>
<td>Dev. Psychology</td>
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<tr>
<td>Comp. Elective</td>
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</table>

General Education Requirements for AAS in Dental Assistant
**DENTAL ASSISTING PROGRAM**

**Application (p.2)**

**WORK EXPERIENCE (within the last ten years)**

<table>
<thead>
<tr>
<th>Type of Work</th>
<th>Name of Employer</th>
<th>Location</th>
<th>From</th>
<th>To</th>
<th>Reason for Leaving</th>
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</thead>
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<tr>
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</table>

Have you ever been cited for Academic Dishonesty?  □ YES  □ NO  If yes, explain: 

Have you ever been charged or convicted of a misdemeanor or felony?  □ YES  □ NO  If yes, explain: 

Please submit copies of documentation of the disposition of charges. Be advised that any adverse results from a background check may disqualify you from admittance to some of the program’s clinical sites and therefore keep you from successfully completing the program.

Signature: __________________________________________ Date: __________________

**IF ANY INFORMATION CONTAINED HEREIN IS FOUND TO HAVE BEEN FALSIFIED, THIS APPLICATION WILL BE WITHDRAWN AND APPLICANT WILL BE ASKED TO WITHDRAW FROM THE SCHOOL.**

A statement of race and financial status is used only for the statistical information required on state and federal forms. Applicants are advised that disclosure of their social security number, date of birth, and information regarding conviction of crimes/infractions is required information for certification requirements as set forth by DANB, and not used to determine a student’s eligibility for the DA Program.

*Labette Community College does not discriminate on the basis of race, color, religion, national origin, sex, age, or qualified handicapped in its education programs, activities, recruitment, admissions, or employment as required by Titles VI, VII, IX, and section 504 of the Rehabilitation Act of 1973. Inquiries should be directed to: Vice President of Student Affairs, Labette Community College, 200 South 14th Street, Parsons, KS 67357. Telephone (620) 421-6700 extension 1264.*

For Office Use Only

TEAS Score ________________  Test Date ________________
Please answer the following questions in essay form (in your own handwriting), include for example, personal experiences, goals and someone who may have influenced your decision. You may use additional paper if needed.

1. Why do you want to become a Dental Assistant?

2. What personal attributes do you possess that would assure your success in the Dental Assistant field?
Please contact us if you have any questions...

Leigh Ann Martin  
Dental Assisting Program Director  
620-232-5820  
leighannm@labette.edu

FAX: 620-232-5870

Jason Sharp  
Dean of Instruction  
620-820-1255  
jasons@labette.edu
ABOUT THE TEAS...

**TEAS** is a multiple-choice assessment of basic academic knowledge in reading, math, science and English and language usage. Schools use this assessment to determine readiness for an allied health program and to ensure your success. The objectives assessed on the TEAS exam are those which allied health educators deemed most appropriate and relevant to measure entry level skills/abilities of healthcare students.

**TEAS Study Manual:** Official TEAS resource specifically written to address each objective that could potentially be addressed on the TEAS exam including Reading, Math, Science and English/Language Usage. Each study guide comes with two additional paper/pencil practice tests with rationales for correct answers. Available in the LCC Bookstore.

NOTE: The TEAS is a proctored exam given at LCC. The Dental Assistant Program will accept TEAS scores earned within one year of the program application deadline.

[http://www.labette.edu/dental/assets/How-to-Register-for-a-TEAS-Assessment.pdf](http://www.labette.edu/dental/assets/How-to-Register-for-a-TEAS-Assessment.pdf)
Health Science Program applicants are expected to truthfully and accurately share any information related to their criminal history—information collected by criminal justice agencies concerning individuals, and arising from the initiation of a criminal proceeding, consisting of identifiable descriptions, dates and notations of arrests, indictments, information or other formal criminal charges and any dispositions arising therefrom—as part of the application and enrollment process. Current students are expected to notify their respective program director if any change in their criminal history occurs while enrolled in an LCC Health Science Program.

Please review the disclosure statement included in the program application packet and sign below indicating the following:

1. I have truthfully and accurately reported my criminal history and pending charges (if any) to the LCC ______ Dental Assisting _______ Program Director.

2. I understand that my criminal history may impact progression in the LCC ______ Dental Assisting _______ Program, and/or ability to be licensed/certified in my field of study.

3. I agree to notify the LCC ______ Dental Assisting _______ Program Director if a change in my criminal history occurs while attending the LCC ______ Dental Assisting _______ Program.

4. The LCC ______ Dental Assisting _______ Program for which I am applying has informed me of the state licensure/certification requirements for that program.

I, ____________________________, have read and understand that completing a criminal background check is required as part the application process for the LCC ______ Dental Assisting _______ Program, and to participate in education courses that include clinical placement.

I authorize Labette Community College to release the results of any criminal background check to any site where I will be placed for any legitimate educational purpose and I waive my privacy rights under the Family Educational Rights and Privacy Act (FERPA) and consent to a background check for this limited purpose.

I hereby release Labette Community College from any liability in the event:

• I am not cleared for placement by the clinical sites and therefore, cannot continue in the program.
• I am unable to obtain the necessary credits to continue in the program due to a criminal charge or conviction that occurred after being accepted into the program.
• I am unable to obtain licensure/certification in my field of study due to adverse results on a criminal background check.

I understand that I cannot be guaranteed placement at a clinical site and if I cannot complete the clinical requirements, I will not be able to graduate from the program.

Print Name: ____________________________

Signature: _______________________________ Date: _______________

Please submit this signed form as part of your application to the LCC ______ Dental Assisting _______ Program.

Contact the Health Science Program Director for information and direction to the appropriate agency for questions regarding criminal history and licensure/certification.
INSTRUCTIONS FOR OBTAINING YOUR BACKGROUND CHECK FOR A CLINICAL EDUCATION PROGRAM

Labette Community College DA

Background checks are required on incoming students to insure the safety of the patients treated by students in the clinical education program. You will be required to order your background check in sufficient time for it to be reviewed by the program coordinator or associated hospital prior to starting your clinical rotation. A background check typically takes 3-5 normal business days to complete. The background checks are conducted by PreCheck, Inc., a firm specializing in background checks for healthcare workers. Your order must be placed online through StudentCheck.

Go to www.mystudentcheck.com and select your School and Program from the drop down menus for School and Program. It is important that you select your school worded as Labette Community College DA

Complete all required fields as prompted and hit Continue to enter your payment information. The payment can be made securely online with a credit or debit card. You can also pay by money order, but that will delay processing your background check until the money order is received by mail at the PreCheck office. Texas residents will pay $53.58 and New Mexico residents will pay $53.27. Residents in all other states will pay $49.50. For your records, you will be provided a receipt and confirmation page of the background check performed through PreCheck, Inc.

PreCheck will not use your information for any other purposes other than the services ordered. Your credit will not be investigated, and your name will not be given out to any businesses.

FREQUENTLY ASKED QUESTIONS:

- Does PreCheck need every street address where I have lived over the past 7 years? No. Just the city and state.
- I selected the wrong school, program, or need to correct some other information entered, what do I do? Please email StudentCheck@PreCheck.com, with the details.
- How long does the background check take to complete? Most reports are completed within 3-5 business weekdays.
- Do I get a copy of the background report? Yes. Log into www.mystudentcheck.com and click on “Check Status”, and enter your SSN and DOB. If your report is complete, you may click on the application number to download and print a copy. This feature is good for 90 days after submittal. After 90 days, you will be charged $14.95 for a copy of your report, and will need to contact PreCheck directly to request this.
- I have been advised that I am being denied entry into the program because of information on my report and that I should contact PreCheck. Where should I call? Call PreCheck’s Adverse Action hotline at 800-203-1654. Adverse Action is the procedure established by the Fair Credit Reporting Act that allows you to see the report and to dispute anything reported.

If you need further assistance, please contact PreCheck at StudentCheck@PreCheck.com.
**Labette Community College**  
**Student Health Record for Healthcare Programs**  
**Physical Examination Form**

<table>
<thead>
<tr>
<th>Student should answer the following questions prior to visit with Primary Healthcare Provider and give details below.</th>
<th>To be completed by your Primary Healthcare Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Please indicate accurate responses</strong></td>
<td><strong>(MD, DO, PA, ARNP only)</strong></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Resp.</td>
</tr>
<tr>
<td>Height</td>
<td>Ft.</td>
</tr>
<tr>
<td>Weight</td>
<td>Lbs.</td>
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</table>

**Musculoskeletal Exam**

<table>
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<th>Nor</th>
<th>Abn</th>
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<tbody>
<tr>
<td>Spine (Symm, ROM)</td>
<td>Shoulder (Symm, ROM)</td>
</tr>
<tr>
<td>Elbow (Symm, ROM)</td>
<td>Wrist/Hand/Fingers (Symm, ROM)</td>
</tr>
<tr>
<td>Rib (Symm, ROM)</td>
<td>Hips/Pelvis (Symm, ROM)</td>
</tr>
<tr>
<td>Knees (Symm, ROM)</td>
<td>Ankles/Feet/Toes (Symm, ROM)</td>
</tr>
</tbody>
</table>

**General**

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<td>E, E, N, T</td>
<td>Dental</td>
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<tr>
<td>Neck</td>
<td>Skin</td>
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<tr>
<td>Heart</td>
<td>Lungs</td>
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<td>Breast</td>
<td>Abdomen</td>
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<tr>
<td>Groin</td>
<td>Genitals</td>
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<tr>
<td>Hernia</td>
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**STATUS (Please Check One)**

| Cleared Unrestricted | Cleared Restricted (please explain below) | Not Cleared (Please explain below) |

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**Company Name:**  
**Policy #:**

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**Additional Comments:**

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**Signature (MD, DO, PA, ARNP only):**  
**Date:**
Labette Community College fully subscribes to all principles and requirements of the American With Disabilities Act of 1990 for qualified handicapped individuals. The Program has developed a list of functional abilities, which are required of students. These functional abilities are skills required of students in the clinical facilities used in the program. Applicants are encouraged to self-identify their accommodation needs as part of the application process. After admission, the students’ health care provider will need to verify in writing that the student has the following functional abilities necessary for successful completion of the program and employment:

- Critical thinking ability sufficient for clinical judgment; including sufficient intellectual functioning and emotional stability to plan and implement care for clients;
- Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds;
- Lift up to 50 pounds and carry up to 25 pounds frequently, but occasionally may exceed these limits;
- Stoop, stand, kneel, crouch and/or crawl at appropriate times as needed;
- Ability to sit for long periods of time in a classroom environment;
- Push or pull with hands and arms as needed;
- Stand and/or walk as the job requires in the performance of duties;
- Manual dexterity with the ability to handle small objects and to perceive size, shape, temperature or texture;
- Visual acuity required to assess client’s condition, to evaluate test results, to discriminate between colors, and to maintain safe environment;
- Communicate, both verbally and in writing, in order to respond to clients, families, and the members of health care team. Read, interpret, and record clinical data appropriately;
- Communicate, both verbally and in writing, as necessary to complete theory assignments such as, but not limited to test-taking, and giving oral reports;
- Hear accurately to perform skills and techniques needed to gather information relevant to the client’s care.

If at any time during the program a student is unable to perform the required functional abilities, the student may not be permitted to continue his/her education. The individual will need to notify the Director of the Program in writing. Documentation by a medical professional may be requested regarding the individual’s ability or inability to perform the functional skills listed above.

To be read and completed by student:

Do you have any physical, mental, or emotional condition requiring continuing management that might affect your ability to perform any of the above Functional Abilities?  ☐ Yes  ☐ No

If “Yes”, please explain: ____________________________

Note: Falsification of information and/or failure to submit information may lead to serious consequences, such as dismissal from the program.

I certify that the above information is true and complete to the best of my knowledge, and hereby authorize my personal physician to furnish Labette Community College, Department of Radiography any and all information they should request concerning my medical history and/or physical condition. A photocopy of this authorization shall be considered as effective and valid as the original.

Signed: ______________________________ Date: ____________________________

Student Signature

To be completed by student’s Primary Healthcare Provider:

I believe the above named student is capable of performing the activities as described on this form.

Signed: ____________________________ Date: ____________________________

Signature (MD, DO, PA, ARNP only)

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<table>
<thead>
<tr>
<th>PROCEDURE/VACCINATION</th>
<th>RESULTS</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td><strong>1) TB SKIN TEST: Need 2 step</strong> Must be complete prior to the start of the program. (Thereafter, annually with documentation provided.) Results of reactions documented as “negative” cannot be accepted. Must be documented in “mm” (millimeters).</td>
<td></td>
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</tbody>
</table>
| Negative : __________ mm 1st Step TB | Negative : __________ mm 2nd Step TB | If Positive  
Date of Chest X-Ray: __________  
Chest X-Ray Result: __________  
If you have received a TB skin test within the last year a 1 Step TB may be all that is required with verification of the 1st one. Please contact the Program Assistant for details. |
| Positive : __________ mm 1st Step TB | Positive : __________ mm 2nd Step TB |  |
| Date Read: __________ | Date Read: __________ |  |
| Initials : __________ | Initials : __________ |  |
| **2) MMR:**  
Two doses of Measles (Rubeola), Mumps, Rubella (German Measles) vaccine required or EVIDENCE OF TITERS: | | If you cannot show proof of 2 doses of MMR vaccine, positive Rubeola & Rubella, or titer you are required to get a MMR Booster. |
| MMR 1st: Date: __________ Initials: __________ |  |  |
| MMR 2nd: Date: __________ Initials: __________ |  |  |
| Rubeola & Rubella: Date: __________ Initials: __________ |  |  |
| MMR Booster Date: __________ Initials: __________ |  |  |
| **3) HEPATITIS B SERIES**  
(or signed waiver):  
Dates: 1st __________ Initials __________ |  | If your series of 3 Hep B vaccinations will not be completed prior to starting the program in which you have been selected you must sign the waiver. |
| 2nd __________ Initials __________ |  |  |
| 3rd __________ Initials __________ |  |  |
| Titer __________ Initials __________ |  |  |
| **4) VARICELLA** (Chicken Pox)  
Screened for immunity or evidence of Titer: Immune: __________ Titer: __________ Date: __________ Initials: __________ |  |  |
| **5) LATEX ALLERGY:**  
Yes  
No  
If yes, provide documentation |  |  |
| **6) TETANUS SHOT** (TDaP):  
Tetanus Shot must have been given within last ten (10) years. Date last tetanus shot given: __________ |  |  |
| **Primary Care Provider:** | **Primary Care Provider:** | **Date:** |
| **Signature** | **Signature** | **Print** |

**Student must read the following statement and sign and date below:**  
To the best of my knowledge the information above is correct and accurate, and I do not currently have a communicable disease that would put clients or patients at risk. I hereby grant permission to the Labette Community College Healthcare Program in which I am enrolling in to release this information to agencies at which I have practicum or clinical experiences.  
**Student:** __________ **Signature** 
**Date:** __________ **Print**  
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WAIVER OF HEPATITIS B IMMUNIZATION

Hepatitis B – is a major cause of viral infection; it results in swelling, soreness, and loss of normal liver function. Signs and symptoms include flu like symptoms such as fatigue, weakness, nausea, abdominal pain, headache, fever, and possibly jaundice. Hepatitis B virus can survive for at least one week in dried blood or on contaminated surface and may be transmitted through contact with these surfaces. Caution must be taken to avoid contact with any blood or other fluid that potentially contains a bloodborne pathogen.

Decline the Hepatitis B Vaccine

I understand that due to my occupation exposure to blood or other potential infectious material, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have read the informed statement on the potential risk and consequences with contraction of hepatitis B. However, I decline to get the hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I may do so at my cost.

_________________________  _________________________  ________________
Student name (Print)  Student Signature  Date