LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Clinical Observation Record

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)
- Offer of acceptance contingent upon—satisfactory physical evaluation, verified by a physician that includes immunization records; 2-step TB skin test; and CPR certification (for healthcare providers). 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.

APPLICATION CHECKLIST

The Dental Assisting Program begins in August of each year.

Before July 8, 2019

- Verify official high school/college transcript(s) are in the LCC Admissions Office
- 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 the 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 7/6/20.

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

ATI TEAS

The link to view the available TEAS testing dates is as follows: http://www.labette.edu/dental/assets/TEAS-Exam-Test-Dates.pdf

Create your account using the "Labette ADN program" tab.

The ATI TEAS Study Guide is available for purchase at www.atitesting.com or on loan at the LCC student success center.

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

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Clinical Observation Record

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.

EXCELLENT			GOOD			SATISFACTORY			FAIR			POOR		
15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

COMMENTS:

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

_____ _____ _____

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

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Statement of Confidentiality

I, the undersigned, as a prospective student of the Dental Assisting Program at Labette Community College, understand that I am assigned to

_____

for 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

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Reference Form

Reference 1

Applicant's Name ____

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*** ***14th Street, Parsons, Kim Martin, DA Program Director, Labette Community College, 200 South***

Personal Qualities	Poor 1	2	Average 3	4	Excellent 5
Professional Appearance					
Cooperation					
Dependability					
Emotional Control					
Honesty					
Judgement					
Punctuality					
Flexibility					
Initiative/Motivation					
Leadership					
Communication Skills					
Organizational Skills					

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

If "Other," please identify relationship ____

Family member references will not be accepted.

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

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Reference Form

Reference 2

Applicant's Name ____

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: Kim Martin, DA Program Director, Labette Community College, 200 South 14th Street, Parsons, KS 67357***

	Poor		Average		Excellent
Personal Qualities	**1**	**2**	**3**	**4**	**5**
Professional Appearance					
Cooperation					
Dependability					
Emotional Control					
Honesty					
Judgement					
Punctuality					
Flexibility					
Initiative/Motivation					
Leadership					
Communication Skills					
Organizational Skills					

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

If "Other," please identify relationship ____

Family member references will not be accepted.

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

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Reference Form

Reference 3

Applicant's Name _____

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.

Return Email, Fax, Mail: Place this form in an envelope, seal the envelope, initial the seal and return email, fax, mail to: Abbi Parish, DA Program Director, Labette Community College, 200 South

	Poor		Average		Excellent
Personal Qualities	**1**	**2**	**3**	**4**	**5**
Professional Appearance					
Cooperation					
Dependability					
Emotional Control					
Honesty					
Judgement					
Punctuality					
Flexibility					
Initiative/Motivation					
Leadership					
Communication Skills					
Organizational Skills					

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

If "Other," please identify relationship _____

Family member references will not be accepted.

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

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Expected Etiquette

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

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Application (Page 1)

General Information

Last Name	First Name	Middle Name	Other Names
DOB		SSN #	
LCC ID #			

Mailing Address

Street/PO Box	City	State	ZIP

Physical Address

Street	City	State	ZIP	County

Email	Phone 1	Phone 2	Phone 3

US Citizen?	YES	NO	Ethnic Background	Native American	Caucasian American
				African American	International
				Asian American	Other

Emergency Contact

Name	Address	Relationship	Phone Number 1	Phone Number 2

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Application (Page 1)

Education				
Are you a high school graduate?	YES	NO	If yes, year graduated:	
If no, high school equivalent?	YES	NO	If yes, year graduated:	
Have you ever attended or applied to a DA program?	YES	NO	If yes, give name and location of school	
Dates attended other DA program			Reason for leaving other DA program	
High School(s)				
College(s)				
Degrees Earned				

For AAS-bound students only:

Please indicate the year, grade, and college of the following General Education Requirements you have completed or mark an X in the *Currently Taking* box.

Course	Year	Grade	Currently Taking	College Initials
Anatomy and Physiology				
English Composition 1				
Fundamentals of Speech				
Applied Math OR				

Intermediate Algebra				
Gen Psychology				
Developmental Psychology				
Computer Elective				

Work Experience

Type of work	Name of Employer	Location	Date began	Date ended	Reason for leaving

Have you ever been cited for academic dishonesty?	Y	N	If yes, explain:	
Have you ever been charged or convicted of a misdemeanor or felony?	Y	N	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:	

Application Essay

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?

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Contact Information

Please contact us if you have any questions...

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

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

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

TEAS Exam

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.

The TEAS Study Manual is an 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. It is 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.

The TEAS Study Manual can be found at the following link: The TEAS Study Manual

Labette Community College
Student Health Record for Healthcare Programs
Physical Examination Form

Name	Date of Birth	Sex

Address

Home Phone Number	Cell Phone Number	Work Phone Number

Student should answer the following questions prior to visit with Primary Healthcare Provider and give details below.

Please indicate accurate responses	Yes	No
Have you had an injury or illness in the past year?		
Have any chronic or recurrent medical problems?		
Have a pin, screw or plate in your body?		
Have any injuries (fractures, sprains, dislocations)		
Had a concussion or head injury resulting in unconsciousness?		
Have a history of anemia?		
Are you allergic to any medications?		
Are you pregnant? (females only)		
Have you ever had anorexia nervosa, bulimia, or compulsive eating behavior?		
History	**Yes**	**No**
Convulsions, seizures, epilepsy		
Frequent or chronic cough		
Diabetes		
Fainting or severe dizziness		
Gastrointestinal disorders or ulcer		
Frequent or severe headaches		
Asthma or shortness of breath		
Chest pain, dizziness, shortness of		

To be completed by your Primary Healthcare Provider

(MD, DO, PA, ARNP only)			
Heart Rate		Temp	
Blood Pressure		Resp.	
Height:	Feet:	Inches:	
Weight:	Lbs.		

General	Nor	Abn
E, E, N, T		
Dental		
Neck		
Skin		
Heart		
Lungs		
Breast		
Abdomen		
Groin		
Genitals		
Hernia		

STATUS (Please Check One)	
Cleared Unrestricted	

breath during or after exercise		
Hearing problems		
Heart problems (murmur, irregular beat)		
Hernia or rupture		
High blood pressure		
Skin disorders (dermatitis, rashes)		
Tuberculosis		
Pneumonia		
Kidney disease or infection		
Liver disease (mononucleosis, etc.)		
Viral diseases (hepatitis, HIV, etc.)		
Bleeding disorders		
Allergies to be stings, foods, or other substances		

Cleared Restricted (please explain below)	
Not Cleared (Please explain below)	
Explain:	

Do you have health insurance? Yes No

If yes: Company Name: Policy Number:

Additional Comments:

Signature (MD, DO, PA, ARNP only) Date

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Background Check

Labette Community College (LCC)
Procedure 3.20 Criminal Background Check Permission and Release Form for Health Science Students

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 _____ Program Director.
2. I understand that my criminal history may impact progression in the LCC _____Program, and/or ability to be licensed/certified in my field of study.
3. I agree to notify the LCC _____ Program Director if a change in my criminal history occurs while attending the LCC _____Program.
4. The LCC _____ 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 of the application process for the LCC _____ 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 may 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 fail to notify the LCC _____ Program Director if a change in my criminal history occurs while attending the LCC Program.

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: _____

Please submit this signed form as part of your application to the LCC Health Science Program.
Contact the Health Science Program Director for information and direction to the appropriate agency for questions regarding criminal history and licensure/certification.

Revised: 5/13/19

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Background Check Instructions

StudentCheck

Look beyond grade point averages.

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

DENTAL ASSISTING PROGRAM

Required Functional Abilities

Functional Abilities Required of Allied Health Students

Labette Community College fully subscribes to all principles and requirements of the Americans 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 (Student): Date:

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Required Functional Abilities

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 *(MD, DO, PA, ARNP only)* Date:

Rev. 1/2011

LABETTE COMMUNITY COLLEGE

DENTAL ASSISTING PROGRAM

Health Records

Labette Community College Student Health Records

Please provide this form or documentation of the information below to the program accepted to.

Check which healthcare program you have been selected to attend:

☐ Nursing Education Program ☐ Respiratory Program ☐ Diagnostic Medical Sonography Program

☐ Radiography Program ☐ Physical Therapist Assistant Program ☐ Dental Assistant Program

Procedure/Vaccination	Results		Comments
1) TB SKIN TEST: Need 2 step 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).	1st Step TB Negative: _____ Positive: _____ Date Read: _____ Initials: _____	2nd Step TB Negative: _____ Positive: _____ Date Read: _____ Initials: _____	If Positive Date of Chest X-Ray: _____ Chest X-Ray Results: _____ 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.
2) MMR: Two doses of **M**easles (Rubeola), **M**umps, **R**ubella(German Measles) vaccine required or EVIDENCE OF TITERS :	MMR 1st: Date:	Initials:	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 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 Signature:	Print Name:	Date:

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:	Print Name:	Date:

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