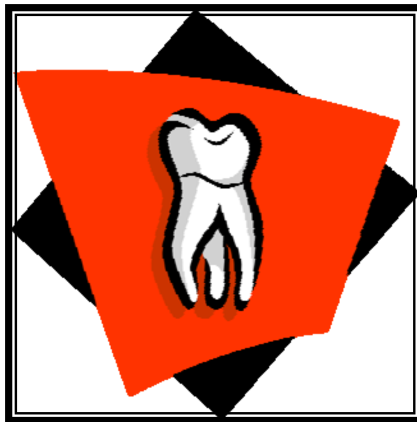
Dental Assistant



First Quarter Student Mandatory Forms

Radiation/Immunizations/Insurance

2017-2018

Dental Assistant

First Quarter Student Mandatory Forms

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SEATTLE VOCATIONAL INSTITUTE
A division of Seattle Central Community College
2120 South Jackson Street · Seattle, WA 98144 · (206) 934-4950
FAX (206) 934-4939

Acknowledgment of Risks, Informed Consent and Agreements Regarding Student's Pregnancy Exposure to Radiation

I, ____, hereby acknowledge and agree as follows:

1. I recognize that students enrolled in the Dental Assistant training program at the Seattle Vocational Institute (SVI) will be actively exposed to dental radiographs in the patient clinical treatment area, similar to the exposure if they were employed in a dental office.

2. I have been informed of the significant potential health risks that arise if I am (or become) pregnant while participation in this training program. I also have been informed that there are state regulations that seek to limit and to require record-keeping of, the radiation dose to an embryo/fetus when an employee is pregnant. See Washington Administrative Code (WAC) 246-221-055. Being so informed, I nevertheless choose to participate in this program and to encounter these risks if I am (or become) pregnant.

3. I realize that any effort or obligation of SVI to follow these pregnancy regulations depends on my voluntarily informing SVI, in writing, of my pregnancy and my estimated date of conception. See WAC 246-221-055 and WAC 246-220-010 (definition of "declared pregnant woman").

4. If I am (or become) pregnant while I am a student in this program, I agree either (a) to inform the SVI dental assistant training coordinator, in writing, of my pregnancy and my estimated date of conception OR (b) that my failure to thus inform SVI shall constitute a WAIVER AND RELEASE, to the fullest extent permitted by law, of any and all claims that I may have or may assert that relate to or are based on excessive exposure to radiation or SVI compliance with laws and rules relating to fetal radiation exposure.

5. I acknowledge that I have been strongly advised that if I am (or become) pregnant while I am a student in this SVI program, I should promptly obtain advice from a physician, preferably in writing, as to what I should do, including whether I should continue radiographic training or withdraw from any course(s) until after delivery. I further acknowledge that the SVI is requesting to be informed of any such advice I receive.

____
Student's Signature Date

____
Printed Student Name Student ID Number

____
Dental Coordinator's Signature Date

____
Executive Dean's Signature Date

PHYSICAL EXAMINATION FOR STUDENTS IN ALLIED HEALTH PROGRAMS

To be completed by a Licensed Physician, D.O. or Nurse Practitioner

Date of Examination _____________________

NAME ____
Last First Middle/Maiden

HOME ADDRESS ____
Street City State Zip Code

PAST HISTORY OF APPLICANT COMMENTS

Allergies/drug reactions ____
Diabetes/endocrine diseases ____
Tuberculosis/respiratory problems ____
Rheumatic fever/heart problems ____
Epilepsy/convulsions/fainting ____
Chronic fatigue/backache ____
Headache/tremors ____
Other illnesses, operations, injuries ____
Psychiatric care ____
What medications does the applicant take routinely? ___________________________________

PHYSICAL EXAMINATION

Age____________ Height___________ Weight_______________
Menstrual History: Regularity_________ Discomfort__________Bed Rest_______________
Eyes: Vision_________________ Breasts _____________________________________
Glasses________________ Heart_____________________________________
Color Vision____________ Lungs _____________________________________
Ears:_______ Hearing/Discharge_______ Blood pressure ______________________________
Nose______________________________ Skin_______________________________________
Throat_____________________________ Abdomen (hernia)__________________________
Sinuses____________________________ Varicose Veins_____________________________
Thyroid____________________________ Joints/feet/arches __________________________
Lymph nodes________________________ Posture ___________________________________
Urinalysis: Specific Gravity____________ Albumin__________Sugar ________________
Additional comments on above item: ____

Is there any physical, medical or emotional reason this person should not undertake this health program?
Do your history and physical findings justify the applicant undertaking this program?

____

How long have you known the applicant? ______________________________

Name of Health Care Provider ______________________________

Address ______________________________

Street City State Zip Code

Signature ______________________________

VACCINATIONS AND IMMUNIZATIONS

The services listed blow may be obtained from Seattle-King County Department of Public Health, one of the local low cost health care agencies, or from your personal health care provider.

NAME______________________ DATE______________________

Annual Tuberculin Test (results) ______________ DATE______________________

*Annual Chest X-ray (results) ______________ DATE______________________

Diptheria-Tetnus (results_ ______________ DATE______________________
(Must be current within 10 years)

Measles/Mumps/Rubella (MMR) (results)__________ DATE______________________
(Born after 1957, need titer. Immunized after 1968 must need date of immunization.)

Hepatitus B series 1st______________ 2nd ______________ 3rd______________
Hepatitus B Titer ______________________________
Chicken Pox Titer ______________________________

Signature ______________________________
Licensed Health Care Provider
(Physician, Immunization Nurse, etc.)

NOTE: This form must be completed and returned to our office before beginning clinicals. Students will not be permitted to attend clinical practice unless this form is complete and on file in the division office by the end of the first quarter.

****

PLEASE RETURN THIS FORM TO: Seattle Vocational Institute
2120 South Jackson Street
Seattle, WA 98144

Attn: Dental Division (Mail Box located SVI – 2nd Floor)
Peggy Camden
(206) 934-4908

Student Immunization Requirements

1. **Measles** - 2 doses live vaccine after 1968 (at or after 15 months of age), or documentation of disease.
2. **Mumps** - 1 dose live vaccine after 1968 (at or after 15 months of age), or documentation of disease.
3. **Rubella**- 1 dose live vaccine after 1968 (at or after 15 months of age), or documentation of disease.
4. **Tuberculosis** - screening on entry in program. Recommend 1 PPD; six months later a second PPD.
5. **Hepatitis** (Unless allergic to eggs or have had hepatitis in the past).
   A. Have begun vaccine series prior to clinical experience. (The series is 3 to 5 injections; or until conversion). There is a 6 to 7 month window of time for the series.
   B. Have shown proof of antibody.
   C. Have shown the school a letter of declination or are refusing vaccine and acknowledging risks involved in that decision.
6. **Diphtheria Tetanus** - If not had in last 10 years.
7. **Chicken Pox** - If no history of exposure, immune titer must be obtained

PPD (TB skin test) Requirement

Anyone taking care of patients, by Washington State law must have a current PPD (TB skin test). Since you will be taking care of patients in the clinical experience, you must bring in your TB skin test results. Your TB skin test must have been taken within the last six months. You will not be able to continue in class or start clinical until you do so! Please bring in a copy of the results to the Allied Health Division Office.

You can get your TB, PPD(skin test), Health and Physicals done at these locations: (by Appointment)

Location	Address	Phone
Downtown	1207 Public Safety Bldg, Room 1207 (3rd & James)	(206) 296-4747
Bellevue	14350 S.E. Eastgate Way, Bellevue	(206) 296-4920
North Seattle	10501- Meridian No.	(206) 296-4838
Southeast	3001 N.E. 4th Renton	(206) 296-4900
Central	Columbia Health Care 4400-37th Ave. S. (37th & Genesee)	(206) 296-4650

The TB skin test will be done one day and you must go back to the clinic to have it read within 48 to 72 hours. If your results are positive, this does not necessarily mean that you have TB but that you may have been exposed at some time. You will then need to have a chest X-ray. If there is evidence of TB you will not be able to continue in the class since you will not be able to take care of patients. If you have a documented prior positive skin test a new test is not recommended but you will need to provide a documented normal chest X-ray.

Vaccination for Hepatitis B

On the following page is a copy of the recommendations from the Center for Disease Control regarding Hepatitis B vaccinations.

The risk of contracting Hepatitis B (common known as serum hepatitis) is related to contact with blood and body fluids of persons with the disease. The incidence of accidental exposure of blood and body fluids is higher among students and graduate medical personnel. The immunization for Hepatitis B may be received at a Public Health Department site or at your own physician's office. The series includes an initial dose and repeated doses at one and six months.
Those students who currently work in health care facilities should check with these facilities as they will provide you with vaccinations free of charge.

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Hepatitis B Immunization Waiver

I have read the information about Hepatitis B and Hepatitis B vaccine and do not wish to receive the vaccine.

______________________________ ____________________
Student Name Date

If you sign this waiver you must turn it in to the Division Office. It will remain in your file Throughout your enrollment in the program or until you obtain your immunization.

Hepatitis B

HBV infection is the major infectious occupational hazard for health care and public safety workers. The risks of acquiring HBV infection are from occupational exposures to blood or blood products. Any health care or public safety worker may be a high risk for HBV exposure depending on the tasks that he or she performs. If those tasks involve exposure to blood for blood contaminated body fluids on at least a monthly basis, then such workers should be vaccinated. Vaccination should be considered for other workers depending on the nature of the task.

Risks among health care professionals vary during the training and working career of each individual but are often highest during the professional training period. For this reason, it is recommended that vaccination be completed during training in schools of medicine, dentistry, nursing, laboratory technology and other allied health professions.

a. Persons at risk for the hepatitis B virus infection who are likely to be susceptible should be actively immunized. Health-care workers who have contact with blood or blood products are at increased risk. These groups include (but are not limited to) physicians, nursing staff, dental professionals and laboratory technicians.

b. Before immunizing serologic screening for hepatitis B need not be done unless the provider considers it cost-effective or the potential vaccine request it.

c. Prophylactics with an immune globulin (passive immunization) and vaccine (active immunization) should be used when indicated, such as following needle-stick or percutaneous exposure to blood that is a high risk for HBsAG – positive. (See MMWR 1985;34:313-324. 329-335 for more details on post exposure prophylactics). Any needle-stick exposure in an unvaccinated person should lead to initiation of the HB vaccine series.

d. Immune globulins should not be used as a substitute when active immunization is indicated.

Recommended from the Center of Disease Control, 1992

Student Health Insurance Waiver

I understand the importance and available sources of health insurance coverage. I do not have a valid health insurance and purchasing such a policy would place undue hardship on me. I do not hold the school or any affiliated institution liable for any illness or accident that may be directly related to being a medical assisting student at Seattle Vocational Institute, and will be responsible for any medical fees as a result.

____

Student Signature

____

Date

*Medical Health Insurance is available to any student by virtue of being enrolled at Seattle Vocational Institute and the Seattle Community College District VI. Fees will vary according to the plan you chose. Inquire at the Registration Desk.

Student Health Insurance Responsibility

I understand that I will be responsible for my own health care coverage and expenses incurred by me while a student in a health program at Seattle Vocational Institute.

I further understand that if it is necessary for me to receive medical care of any kind, including Emergency Room treatment, in the clinical setting, I will be responsible for any charges incurred.

I have health insurance through____.

_______________________________________ _____________________________
Student Signature Date

SEATTLE VOCATIONAL INSTITUTE

DISCLOSURE – Criminal Background Check (Completed during registration process and upon Program Acceptance)

Dental Assistant Program

I understand that Seattle Vocational Institute does not discriminate in any course of study. I further understand that a felony conviction or convictions and/or unacceptable Washington State Patrol Criminal Background Check, if any, will prevent me from being placed on externship sites and completing the program. I therefore authorize Seattle Vocational Institute to perform a Washington State Patrol Criminal Background Check on me as required by our externship sites so that we do not place a student with a felony conviction or convictions with these externship partners.

I understand that Seattle Vocational Institute's responsibility is to train me in my chosen field and inform me of known obstacles to my success in that field. The school does not guarantee me a job in my field in any case, but is making clear to me that it will be difficult or impossible to secure employment in this field if I have a felony or other convictions that are unacceptable in the Washington State Patrol Criminal Background Check.

Signatures

_______________________________ __________

Student Date

_______________________________ __________

SVI Representative Date

Please Print.

First Name: _______________________________

Last Name: _______________________________

Maiden Name: _______________________________

Gender: Female ______ Male ______

Date of Birth: mm/______ dd/__________ yyyy/________

Information on this form is confidential and will only be used for SVI internal purposes as stated above.

WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633, Olympia WA 98504-2633

REQUEST FOR CRIMINAL HISTORY INFORMATION
CHILD/ADULT ABUSE INFORMATION ACT
RCW 43.43.830 THROUGH 43.43.845

(Completed at Registration)

A REQUESTING AGENCY/ADDRESS

____
Agency

____
Attn

____
Address

____
City/State/Zip

I certify this request is made pursuant to and for the purpose included.

____
Authorized Signature Date

____
Title Area Code/Phone Number

B PURPOSE

Check appropriate box

- ☐ Educational School District (ESD)/School District Volunteer - no fee
- ☐ Non-Profit Business/Organization - no fee (Excluding Schools & ESD's)
- ☐ Profit Business/Organization - $10
- ☐ Adoptive Parent - $10

Fees: Make payable to **Washington State Patrol** by cashier's check, money order, or business account.

No Personal/Certified Checks Accepted

C APPLICANT OF INQUIRY (please provide as much information as possible name and date of birth are mandatory)

Applicant's Name: ______________________________
Last First Middle

Alias/Maiden Name(s): ______________________________

Date of Birth: ____________ Sex: ____________ Race: ____________

Social Security Number: ____________ Driver's License Number/State: ________ / ____________

Secondary dissemination of this criminal history record information response is prohibited unless in compliance with RCW 10.97.050.

IDENTIFICATION DECLARING NO EVIDENCE
WASHINGTON STATE PATROL IDENTIFICATION & CRIMINAL HISTORY SECTION

As of this date, the applicant named below shows no evidence pursuant to RCW 43.43.830 through 43.43.845.

____
Requesting Agency

____
Applicant's Signature

____
Applicant's Name

____
Address

____
City/State/Zip

WSP Use Only

Valid Two Years From Issue

Applicant
Right
Thumb
Print
(Optional)

MAIL COMPLETED FORM TO:
WASHINGTON STATE PATROL
IDENTIFICATION AND CRIMINAL HISTORY SECTION
PO BOX 42633
OLYMPIA, WA 98504-2633

For further information contact the Washington State Patrol at:
Phone: (360) 705-5100
E-mail: crimhis@wsp.wa.gov
Web: http://www.wa.gov/wsp/

CHILD/ADULT ABUSE RECORD SEARCH GUIDELINES:

Refer to Revised Code of Washington (RCW) 43.43.830-43.43.845 for complete information. Child/Adult Abuse Information Act background checks may be conducted by Washington state businesses, organizations or individuals. All other states must conduct searches under the Criminal Records Privacy Act, RCW 10.97.

1. ***Searches can be conducted only on prospective employees, volunteers or adoptive parents.***
   Background checks can be conducted on prospective employees, volunteers, or adoptive parents who will or may have unsupervised access to children under sixteen years of age, developmentally disabled persons, or vulnerable adults. The background check is for initial employment or engagement decisions only.
   Background checks on current employees or volunteers should be done through the Criminal Records Privacy Act, RCW 10.97
2. ***Applicants must be notified an inquiry may be made.***
   A business or organization shall not make an inquiry to the Washington State Patrol unless the business or organization has notified the applicant, applying for a position as an employee or volunteer that an inquiry may be made.
3. ***A business or organization must prepare a disclosure statement to be signed by the applicant before a background check may be conducted.***
   A business or organization shall require each applicant to disclose whether the applicant has been:
   (a) convicted of any crime against children or other persons;
   (b) convicted of crimes relating to financial exploitation if the victim was a vulnerable adult;
   (c) convicted of crimes related to drugs as defined in RCW 43.43.830;
   (d) found in any dependency action under RCW 13.34.040 to have sexually assaulted or exploited any minor or to have physically abused any minor;
   (e) found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor;
   (f) found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult;
   (g) found by a court in a protection proceeding under chapter 74.34 RCW, to have abused or financially exploited a vulnerable adult.

   The disclosure shall be made in writing and signed by the applicant and sworn under penalty of perjury. The disclosure sheet shall specify all crimes against children or other persons, all crimes relating to drugs, and all crimes relating to financial exploitation as defined in RCW 43.43.830 in which the victim was a vulnerable adult.
4. ***Applicants must be notified of the response.***
   The requesting agency shall notify the applicant of the Washington State Patrol's response within ten days after receipt. The employer shall provide a copy of the response to the applicant and shall notify the applicant of such availability.

WASHINGTON STATE PATROL RESPONSE

This identification certificate is the result of a request for criminal conviction record information from the Washington State Patrol Identification and Criminal History Section on a prospective applicant by a business or organization. Pursuant to the Child/Adult Abuse Information Act, RCW 43.43.830 through 43.43.845, if the conviction record, disciplinary board final decision, or civil adjudication record shows no evidence of a crime against children or other persons, an identification declaring the showing of no evidence shall be issued to the applicant.

WASHINGTON STATE PATROL
Identification and Criminal History Section
PO Box 42633
Olympia WA 98504-2633

REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD
INSTRUCTIONS:
PLEASE COMPLETE THIS FORM WHEN REQUESTING **CONVICTION** CRIMINAL HISTORY RECORD INFORMATION FROM THE WASHINGTON STATE PATROL IDENTIFICATION AND CRIMINAL HISTORY SECTION. MAIL REQUEST TO ADDRESS NOTED ABOVE WITH **$10 MONEY ORDER, COMMERCIAL BUSINESS ACCOUNT CHECK OR CASHIER CHECK,** (no personal checks), PAYABLE TO THE WASHINGTON STATE PATROL.

NOTE: The requested record information is furnished solely on the basis of name and/ or description similarity with the subject of your inquiry. Positive identification or non-identification can only be effected upon receipt of fingerprints. Subject may be advised of inquiry.

A SUBJECT INFORMATION: (Please provide as much information as possible in space below)

Applicant's Name ____
Last First Middle

Alias/ Maiden Name: ____

Date of Birth: ________________ Sex: ____________________ Race: ______________________
Month/ Day/ Year

Social Security Number: ______________ Drivers License Number/ State: ______________ / ______

WSP Use Only

B REQUESTER INFORMATION:

Date: ____
Mo. Day Yr. (print) Name / Title of Requester

Phone No. ( ) ____
Requester's Signature

Requester's Address: (type or clearly stamp address)

____

____

____

Right Thumb Print (Optional)