Dental Assisting Student - 2020
Demographic Profile for ADA

This demographic survey is being used for information needed to complete the American Dental Association Annual Survey of Dental Programs and for newsletter releases for the Redwood Empire Dental Society.

Thank you for your cooperation.

Print Name _____

Please Circle the best answer for each question

1. **Sex** male Female

2. **Please circle that best describes your age range**:
23 and under 24 to 29 30 to 34 35 to 39 40 and over

3. **Please circle the citizenship that best describes your status**:
US citizen Canadian citizen Non-resident Alien Resident Alien other

4. **What is the highest level of education you have completed**?
High school diploma less than one year of college one year of college

Two years of college Associates Degree – AS or AA three years of college

Four years of college Bachelor's degree – BS or BA other_____

5**. Race/Ethnicity Description from DBC Accreditation– please circle the race/ethnicity that describes you best**

American Indian or Alaskan Native	A person having origins in any of the original peoples of North and South America (including Central America) who maintains cultural identification through tribal affiliations or community attachments.
Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan the Philippine Islands, Thailand and Vietnam
Black or African-American	A person having origins in any of the black racial groups of Africa

Hispanic or Latino (any race)	A person of Cuban, Mexican, Puerto Rican, South or Central America or other Spanish culture or origin, regardless of race.
Native Hawaiian or other Pacific Islander	A person having origins I any of the original peoples of Hawaii, Guam, Samoa or another Pacific Islander
White	A person having origins in any of the original peoples of Europe, the Middle East or North Africa
Two or more races	Category used for individual who identify with two or more race categories listed above
Unknown	Category used to classify persons whose race and ethnicity are not known
Nonresident Alien	A person who is not a citizen of the United States and who is in the country on a visa or temporary basis and does not have the right to remain indefinitely

6. Are you comfortable speaking any other language(s) – if so, please list the language(s)

_____

7. **Please respond to the following questions with a "yes" or "no" answer** Have you requested financial assistance yes no

Will you receive financial assistance when you begin the program yes no

When you <u>begin</u> the program will you be employed yes no

If yes, approximately how many hours per week _____

If yes, type of work you will be doing when you <u>begin the program in the Fall</u>

_____

Do you have family care responsibilities yes no

8. **In what county (not country) and state did you live prior to enrollment in the program**?

County (i.e. Sonoma, Marin, Lake)_____

State _____

9. **In what county (not country) do you plan to live following graduation**?

County (i.e. Sonoma, Marin, Lake)_____

State _____

10. **Do you have previous experience working in a dental office**?

As a DA/sterilization assistant _____ number of years_____ ?

As a dental office receptionist _____ number of years _____?

GETTING TO KNOW YOU
Please print clearly

Name_____

Address_____

Phone #_____

E-mail_____

Emergency Contact and Phone #_____

Why did you choose to become a dental assistant?

_____

_____

_____

_____

_____

_____

Please share any specific information that can assist the faculty to help you in your success in the dental assisting program

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SRJC Health History Form -
DA or DH Student

Name: _____ Home Phone ( )_____ Cell Phone ( ) _____
Last First Middle
Address _____ City_____ State_____ Zip Code _____
P.O. Box or Mailing address
Occupation _____ Business Phone _____ Date of Birth ____/____/____ Sex ☐M ☐F

Email_____ Text message _____

Emergency Contact _____ Relationship _____ Phone (___)_____

For the following questions, please *circle* **YES / NO / DON'T KNOW** or write in the appropriate response. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. SRJC does not use this information to discriminate**.**

Medical Information

1. How would you rate your health? ☐ Good ☐ Fair ☐ Poor
2. Has there been any change in your general health within the past year? ……...…..Yes No Don't Know
   If yes, explain_____
3. My last physical examination was on _____
4. Are you under the care of a physician?...Yes No Don't Know
   If so, what is the condition being treated? _____
   _____
5. The name and address of my physician(s) is
   Name_____
   Phone_____
   Street Address _____
   City/State/Zip_____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?..... .....Yes No Don't Know
   If so, what was the illness or problem? _____
   _____
7. Are you taking or have you recently taken any of the following medications?
   a. Antibiotics or sulfa drugs..... Yes No Don't Know
   b. Anticoagulants (blood thinners) ..... Yes No Don't Know
   c. High blood pressure medication...…... Yes No Don't Know
   d. Cortisone ..... Yes No Don't Know
   e. Aspirin ..... Yes No Don't Know
   f. Bisphosphonates. …….....Yes No Don't Know
   g. Insulin, tolbutamide…….....Yes No Don't Know
   h. Digitalis..... Yes No Don't Know
   i. Nitroglycerin..... Yes No Don't Know
   j. Antihistamine..... Yes No Don't Know
8. Are you taking any medication(s) including non-prescription and herbal medications? If so, what medicine(s) are you taking?
   Prescribed:
   _____
   _____
   _____
   _____
   _____
   Over the Counter:_____
   _____
   Natural/herbal preparations_____
   _____
9. Do you have active Tuberculosis?..... Yes No Don't Know
10. Do you have a persistent cough greater than a 3 week duration or cough that produces blood?..... Yes No Don't Know

Bleeding Problems

11. Have you had abnormal bleeding?..... Yes No Don't Know
12. Have you ever had a blood transfusion? Yes No Don't Know
    If yes, when _____
13. Do you have a blood disorder (anemia, hemophilia, leukemia)?.....…… Yes No Don't Know
    If yes, please explain_____

Premedication (Antibiotic)

14. Has a dentist or physician ever recommended that you take antibiotics prior to dental treatment?..... Yes No Don't Know
    if yes, for what condition? _____
15. Do you have any of the following medical problems?
    a. Prosthetic cardiac valve……..…….. Yes No Don't Know
    b. Previous endocarditis…….. Yes No Don't Know
    c. Congenital heart disease, unrepaired, including palliative shunts and conduits…… Yes No Don't Know
    d. Congenital heart disease, repaired, with prosthetic device…….. Yes No Don't Know
    e. Cardiac transplantation…….. Yes No Don't Know
16. Have you had an orthopedic total joint (knee, hip or other joint) replacement?. . Yes No Don't Know
    If yes, date of surgery? _____
    a. For this condition, has your surgeon directed you to take antibiotics before dental treatment yes _____ no _____

Cardiovascular Diseases

17. Have you had a heart attack?...…… Yes No Don't Know
    If yes, When?_____
18. Have you had a stroke?...……..…… Yes No Don't Know
    If yes, When?_____
19. Do you have chest pain upon exertion? Yes No Don't Know
20. Are you ever short of breath after mild exercise or when lying down?. ……..…… Yes No Don't Know
21. Do you have a cardiac pacemaker?..... Yes No Don't Know
22. Do you have any of the following Cardiovascular problems?
    a. Coronary insufficiency..... Yes No Don't Know
    b. Angina……..... Yes No Don't Know
    c. High blood pressure….....Yes No Don't Know
    d. Low blood pressure….....Yes No Don't Know

Diabetes

23. Do you have Diabetes? ……..... Yes No Don't Know

IF YES, please answer the next three questions:

What type? ……Type I____ Type II____
Have you eaten today? …… Yes____ No ____
What was you glucose count this morning? _____

Other Diseases

24. Have you ever had any treatment for a tumor or growth (surgery, radiation, or chemotherapy)?.. Yes No Don't Know
If yes, please explain_____

25. Do you have or have you had any of the following diseases or problems?

a. Asthma or hay fever……..Yes No Don't Know
Do you have your inhaler with you? Yes ____ No ____
b. AIDS or HIV infection……..... Yes No Don't Know
c. Arthritis, rheumatism..... Yes No Don't Know
d. Cancer…… Yes No Don't Know
e. Chronic pain…….. Yes No Don't Know
f. Eating Disorder…… Yes No Don't Know
g. Epilepsy …… Yes No Don't Know
h. Fainting spells or seizures…… Yes No Don't Know
i. G.E. reflux……..... Yes No Don't Know
j. Glaucoma……..…….. Yes No Don't Know
k. Hepatitis, jaundice or liver disease… Yes No Don't Know
l. Kidney Trouble.....…..... Yes No Don't Know
m. Mental Health Problems……..Yes No Don't Know
n. Mononucleosis..... Yes No Don't Know
o. Oral herpes/ cold sores/ fever blister. Yes No Don't Know
p. Osteoporosis.....…..... Yes No Don't Know
q. Persistent swollen glands in neck…... Yes No Don't Know
r. Problems of the immune system...… Yes No Don't Know
s. Recurrent infections…… Yes No Don't Know
t. Respiratory problems……..... Yes No Don't Know
If yes, please specify type (emphysema, bronchitis, other)
_____
u. Severe headaches……..…... Yes No Don't Know
v. Sexually Transmitted Disease (syphilis, gonorrhea, chlamydia, etc).....….....Yes No Don't Know
w. Sinus trouble……..Yes No Don't Know
x. Stomach ulcer or hyperacidity..... Yes No Don't Know
y. Systemic lupus erythematosus……Yes No Don't Know
z. Thyroid problems……..….. Yes No Don't Know
e. Arteriosclerosis ……..... Yes No Don't Know

Allergies

26. Are you allergic or have you had a reaction to:

a. Aspirin……..... Yes No Don't Know
If yes, specify reaction_____
b. Barbiturates.....Yes No Don't Know
If yes, specify reaction_____
c. Codeine or other narcotics.....Yes No Don't Know
If yes, specify reaction_____
d. Food…….....Yes No Don't Know
If yes, specify food and reaction_____
e. Iodine……..Yes No Don't Know
If yes, specify reaction_____
f. Latex.....Yes No Don't Know
If yes, specify reaction_____
g. Local anesthesia…….....Yes No Don't Know
If yes, specify reaction_____
h. Penicillin.....Yes No Don't Know
If yes, specify reaction_____
i. Seasonal allergies……Yes No Don't Know
If yes, specify reaction_____
j. Sulfa drugs…….....Yes No Don't Know
If yes, specify reaction_____
k. Other.....Yes No Don't Know
If yes, specify reaction_____

27. Do you have any disease, condition, or problem not listed that I should know about?.....Yes No Don't Know
If so explain_____

Tobacco/Alcohol/Drugs

28. Do you use tobacco of any type?..... Yes ____ No ____
If so, which type? _____ How long?_____
29. Are you a former tobacco user?..... Yes ____ No ____
30. Do you currently use alcoholic beverages? Yes ____ No ____
31. Are you in recovery for alcoholism/substance abuse?.....Yes____ No____
32. Do you use recreational drugs?.....Yes ____ No ____
33. Do you use medical marijuana?……..Yes_____ No____

For women only:

34. Are you pregnant?..... Yes No Don't Know
If yes, due date?_____
35. Are you taking birth control (pills, injections or implants)?..... Yes No Don't Know
If yes, please explain_____
36. Are you taking hormone replacement?.....Yes No Don't Know

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold SRJC, or any member of the staff, or student, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient/ student Date

Print Name Clearly _____

SRJC Dental History Form

1. The name and address of my dentist is:
   Name_____ Phone_____

   Street Address_____ City/State/Zip_____

2. Date of last dental cleaning _____ Date of your last dental x-rays_____

3. Are you nervous about receiving dental treatment?
   Yes ___ Explain why_____ No ____

4. Are you experiencing any of the following symptoms (Circle any that apply)

My teeth are Sensitive to:	I have (an):		I am worried about:
Hot	Abscess	Difficulty Chewing	Gum Recession
Cold	Toothache/Broken Tooth	Difficulty Swallowing	Dry Mouth
Sweet	Burning Sensation	Calculus Buildup	Bad Breath
Pressure	Filling that fell out	Other Concern:_____	

5. Have you experienced any of the following? When (month, year)?

Root planning	_____	Head/neck radiation therapy	_____	Bad reaction to a local anesthetic	_____
Root Canal	_____	Periodontal Surgery	_____	Headaches, earaches or neck pains	_____
Tooth extraction	_____	Prolonged bleeding after	_____	Other	_____

6. Have you ever had orthodontic (braces) treatment? Yes _____ If yes, for how long? _____ No _____

   Did you wear a retainer? Yes _____ permanent or removable? _____ No _____

7. Do you wear a removable dental prosthesis (denture, partial)? Yes _____ No _____

8. Do you have any dental implants? Yes _____ No _____

9. Do you clench or grind your teeth in the daytime or at night? Yes _____ No _____

   If yes, do you wear a night guard/ bite guard?_____ For how long? _____

10. Have you experienced any injuries to your teeth, face or jaw?
    Yes _____ Explain_____
    No _____

11. About how many times each day / week do you brush and floss?
    Brush: _____ x per day OR _____ x per week **Floss:** _____ x per day OR _____ x per week

12. Do you agree or disagree with this statement: Oral health affects general health.

    Strongly agree Agree Disagree Strongly disagree

13.

When you look inside your mouth, do you look for any of the following?	Yes	No	Don't Know How
Caries			
Oral Cancer			
Cold Sores			
Gingival Disease			

14. In the past two years, have you been concerned about your breath or the appearance of your teeth or face?
    Yellowing/ graying teeth Spacing between teeth Other
    Stains Gingiva Breath

Vaccination / Declaration & Declination Form

Student: _____

Student Identification Number: _____

Program: _____

I have been advised that the Hepatitis B vaccination and verification of immunity and carrier status are required for the clinical assignments in the Dental Programs. I understand that due to the possible occupational exposure to blood or other potential infectious materials I may be at risk of acquiring Hepatitis B viral infection.

Please check one of the following:

_____ I have completed the Hepatitis B vaccination series (must submit documentation).

_____ I am currently in the process of Hepatitis B vaccination and have received _____ vaccination(s) at this time (must submit documentation)

_____ I decline to be vaccinated at this time.

I am aware that I can waive the Hepatitis B vaccination requirement only by signing this Vaccination Declination form. In that case, I continue to be at risk of acquiring Hepatitis B, a serious disease.

In the future, should I decide to be vaccinated for Hepatitis B, I will provide documentation of this to the program director.

_____ _____

Student Signature Date

SANTA ROSA JUNIOR COLLEGE
Department of Health Sciences
Dental Assisting and Dental Hygiene Programs
Confidentiality of Patient/Student Externship/Internship Information

Inherent in health care is both a legal and ethical responsibility to protect the privacy of patients. Consequently, the indiscriminate or unauthorized review, duplication (including photographic), use or disclosure of personal information, medical, dental or otherwise, from any source regarding any patient is expressly prohibited. In regards to photographs of patients/persons in clinic, if the face can be seen, the image may not be used in any form unless a photo release form has been signed.
Except when required in the regular course of clinic business, the discussion, use, transmission or narration, in any form, of any patient information that is obtained in the regular course of study is strictly forbidden. When you are referring to patient during a patient seminar or in a report, only first names will be used.
Under no circumstances may any part of a patient's record be duplicated (including photographic duplication)
Any violation of this policy shall constitute grounds for corrective conferencing.

_____ _____ _____
Student's Signature Student's Name -- Please Print Date

Inherent in health care is both a legal and ethical responsibility to protect the privacy of students in both programs. Consequently, the indiscriminate or unauthorized review, use or disclosure of personal information, medical, dental or otherwise, from any source regarding any student is expressly prohibited. In regards to photographs of students in clinic, if the face can be seen, the image may not be used in any form unless permission is obtained from the student.
The department requires a photo release form to be signed for student's photos for educational and PR purposes.
Any violation of this policy shall constitute grounds for corrective conferencing.

_____ _____ _____
Student's Signature Student's Name -- Please Print Date

Inherent in health care is both a legal and ethical responsibility to protect the privacy of all persons involved in the externship/internship programs. Consequently, the indiscriminate or unauthorized review, use or disclosure of personal information or business practice from any source regarding any externship/internship is expressly prohibited.
Any violation of this policy shall constitute grounds for corrective conferencing.

_____ _____ _____
Student's Signature Student's Name -- Please Print Date

The lines between public and private, personal, and professional are blurred in online social networks. The following suggest "best practices" for all professionals.

1. be respectful
2. respect confidentiality, conform to all policies regarding the confidentiality of information regarding patient, student and externship/internship settings
3. assume that any posting is public regardless of the privacy settings
4. assume that any posting is permanent

Any violation of this policy shall constitute grounds for corrective conferencing.

_____ _____ _____
Student's Signature Student's Name -- Please Print Date

Release Authorization to use Physical Likeness

I hereby give permission to Santa Rosa Junior College (SRJC) to use my name, image, voice, likeness, information, photographs, video and sound recordings (collectively "Image") for all purposes, including but not limited to: use in instruction, publications, media, advertising, or other promotional purposes by SRJC. I understand and agree that I will not receive any compensation for SRJC's use of my Image.

I understand that this Release Authorization is voluntary and my Image may be protected under the Family Educational Rights and Privacy Act (FERPA) as a student record, for which I now authorize this release to SRJC for the uses stated above. I shall have no right to title, or interest in the materials for which my Image may be used. I release SRJC from all liability related to the use of my Image. Any Image retained by SRJC will not be sold or given to another agency or organization for their commercial purposes.

I warrant that I have no legal restrictions on my ability to authorize the release of my Image. This agreement constitutes the sole, complete, and exclusive agreement between me and SRJC, which I have read, understand, and agree to. A copy of this Release is as good as the original.
I understand that this Release does not release my personal information or any intraoral photographs/images used for educational classroom purposes.

	Dental Assisting Student / Dental Hygiene Student
FULL NAME *(please print)*	**Please circle program entered**
SIGNATURE - Student	**DATE**
SIGNATURE – Witness	**DATE**

Office of Public Relations, Santa Rosa Junior College, 1501 Mendocino Ave, Santa Rosa, CA 95401-4395, (707) 527-4266

Revised – dental programs 4/20

INFECTIOUS DISEASE POLICY

The risk of contracting Hepatitis B virus (HBV), Hepatitis C, or other infectious diseases are greater than the risk of contracting human immunodeficiency virus (HIV). Therefore, recommendations for the control of Hepatitis B & C infections will effectively prevent the spread of AIDS. All such recommendations are therefore incorporated herein.

1. Sharp items (needles, scalpel blades, and other sharp instruments) shall be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries. Proper disposal of sharp items according to Cal/OSHA guidelines shall be followed.

2. Disposable syringes and needles, scalpel blades and other sharp items should be placed in puncture resistant containers located as close as practical to the area in which they were used. To prevent needle stick injuries, needles shall not be recapped, purposely bent, broken, removed from syringes, or otherwise manipulated by hand.

3. When the possibility of exposure to blood or other body fluid exists, routinely recommended universal precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or other body fluids, or may also require gowns, masks, hair, eye and face coverings when performing procedures. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood or body fluids.

4. Pregnant Dental Assisting/Hygiene students are <u>not known</u> to be at greater risk of contacting the HBV, HCV or HIV than students who are not pregnant. However, if a student develops infection with HBV, HCV or HIV during pregnancy, an infant has an increased risk of infection through prenatal or perinatal transmission. Because of this risk, pregnant students should be especially familiar with precautions for HBV, HCV and HIV.

5. Dental Assisting/Hygiene students engaged in health care who are infected with the HIV or HBV, HCV and who are not involved in invasive procedures need not be restricted from work unless they have some other illness for which any health care worker would be restricted.

6. For Dental Assisting/Hygiene students engaged in health care who have been diagnosed as HIV positive, there is an increased danger from infection due to disease. Students who are HIV infected are at risk of acquiring or experiencing serious complications of such diseases. Of particular concern is the risk of severe infection following exposure to patients with easily transmitted infectious diseases (e.g. tuberculosis, chicken pox, SARS). HIV infected students will be counseled about potential risk precautions to minimize their risk of exposure to other infectious agents.

7. The Dental Assisting/Hygiene student's physician, in conjunction with the appropriate college official, will determine on an individual basis whether the student who is HIV or HBV positive, with symptoms, can adequately and safely perform patient care.

8. A Dental Assisting/Hygiene student with an infectious disease who cannot control bodily secretions and students who have oozing lesions will not be permitted to participate in health care services. The determination of whether an infected student should be excluded from providing health care shall be made on a case-by-case basis by the student's physician and the appropriate college officials.

9. Dental Assisting/Hygiene students who are exposed to infectious body fluids in the clinical area must report to the supervisor/clinical instructor immediately. The clinic shall be notified and the clinic protocol for such exposure followed. In addition, program directors must be notified as soon as possible to assure proper follow-up in the event of blood borne pathogen exposure.

I have read and understand this policy:

Signature_____ Date_____

Informed Consent

I, _____, understand that as a clinical student, I may be exposed to environmental hazards and infectious diseases including, but not limited to Tuberculosis, Hepatitis B, Hepatitis C and HIV (AIDS) while in a clinical facility.

Neither Santa Rosa Junior College nor any of the clinical facilities used for clinical practice assumes liability if a student is injured on the campus or in the clinical facility during training unless the injury is a direct result of negligence by the college or clinical facility. I understand that I am responsible for the cost of health care for any personal injury I may suffer during my education. I understand that I should purchase private health insurance.

I further understand that I must have liability insurance (which covers malpractice) while enrolled in classes involving clinical activities. This insurance fee must be paid **each** year at the fall registration.

I understand and assume responsibility for the policies, objectives, course requirements and inherent risks involved in the education of Dental Assisting/Hygiene students at Santa Rosa Junior College.

_____	_____
Student Name (please print)	Student Id Number
_____	_____
Signature	Date

Santa Rosa Junior College
Allied Dental Education Program
Structure of Clinical Education Agreement

The faculty in the dental programs at Santa Rosa Junior College utilizes a team teaching approach to impart clinical skills to dental assisting and dental hygiene students. In each preclinical and clinical session, individual and collaborative instruction and observations provide students with the greatest opportunity for clinical skill development. Verbal and written feedback is provided at each session to ensure that students are informed of their progress in the development of such skills. The instructors are required to read one another's written documentation and consult with one another regarding student progress in skill development. This team teaching and clinical education structure enables the faculty to focus on individual student needs.

Students are asked to write goals for preclinical sessions and make entries in journals after clinical sessions. This documentation is read by all the clinical instructors and in some cases, the program director. Students meet with their course lead instructor at set times during each semester and by appointment when the student or the faculty deems it necessary.

As part of the program outcomes assessment plan and the quality assurance in patient care plan, student evaluation forms are read at successive patient appointments and clinic sessions to gather information pertinent to the aforementioned plans. Instructors are required to question students, patients, clinical staff, and other faculty members about documentation on evaluation forms to ascertain that patients have been, and will be receiving the *Standard of Care* described in the *Patient Bill of Rights* document.

Students will experience diverse teaching styles in clinic and lab. Instructional diversity provides a rich environment for learning. In order to obtain maximum learning in the clinical environment, it is important to learn to appreciate the knowledge, background, and experience of each clinical and laboratory instructor.

Teaching psychomotor skills may sometimes require close proximity or hand contact of the instructor to the student.

By signing this agreement, you are indicating that you have read and understand the method and structure utilized by the faculty and that you hereby grant permission to the faculty to read your performance evaluations and consult with one another about your progress in clinical skill development and the delivery of patient care.

_____ _____

Print Name *Indicate DA, DH Program*

*Date Entering Program*_____ *Month/Year Scheduled to Graduate*_____

Physicians Awareness of Pregnancy *

_____
Student's Name

The above-mentioned student is presently enrolled in the Dental Assisting/Hygiene Program at Santa Rosa Junior College. Due to the nature of the Program, this student may risk exposure to ionizing radiation, Nitrous Oxide or possible exposure to contagious disease. In order to determine the appropriate precautions, we need the following information.

1. Date of Conception: (approximate) _____

2. Date of Expected Delivery: (approximate) _____

3. Present health status: _____

4. Will the patient be under your care during her pregnancy? Yes No

5. Have you informed her of the potential danger involved in continuing her present career goal while pregnant? Yes No

6. Do you recommend her continuation in the dental assisting/hygiene program? Yes No

7. Do you recommend any limitation to regular duties? If yes, please explain. Yes No

Any limitations recommended? _____
_____

_____ _____
Physician's Name Physician's Address

_____ _____
Physician's Signature Date

_____ _____
Student Signature Date

Pregnancy Policies & Radiography *

The following agreement pertains to any student who is pregnant or who is planning a pregnancy while enrolled in the SRJC Allied Dental Programs. Any student exposing radiographs in the Dental Radiography course (DE55A, DE 55B), Clinical courses (DH71C-E) or at any Externship site must comply with the following guidelines:
(Please initial each statement as read)

_____ If I become pregnant, I agree to consult my physician regarding this issue and to provide adequate documentation, in writing, to that effect to the dental program office.

_____ I agree to adhere to all SRJC Dental Radiography safeguards and guidelines pertaining to proper radiologic technique as stated in the course documents.

_____ I understand that I must complete all radiography requirements prior to graduation from the program. This may require a delay in completion of the program.

_____ _____
Signature (student) Date

_____ _____
Signature (faculty) Date

_____ _____
Program Director Date

Student Agreement

Read and Check Each of the Following before Signing

I have read Dental Programs Student Handbook. I affirm that I will be responsible for all the data herein. My initial indicates that I understand and am aware of the following content consisting of:

_____ Dental Programs Accreditation
_____ Dental Hygiene and Dental Assisting Curriculum
_____ Program Philosophy
_____ Program Goals and Competencies for Dental Hygiene/Dental Assisting Program
_____ Santa Rosa Junior College and Dental Programs Policies
    _____ Student Code of Conduct
    _____ Access for Student with Disability
    _____ Discrimination Policy
    _____ Sexual Harassment
_____ Patient and Student Treatment Policies
    _____ Patient Privacy Policies
    _____ Confidentiality
    _____Patient Bill of Rights
_____ General Department Guidelines
    _____ Student Security
    _____ Student Educational Rights
    _____ Communication
    _____ Posting Notices of Services
    _____ Food and Drink, Locker Room and Building Maintenance
    _____ Children and Visitors
_____ Student Conduct
    _____ Professionalism and Ethics
    _____ Dress Code & Professional Image
_____ Academic and Attendance Policies
    _____ Attendance Policy
    _____ Academic Policy
    _____ Student Probation and Request Withdrawal
    _____ Academic Grievances

_____ Grading Policies
_____ Technical Standards
_____ Health Requirements and Policies
_____ Blood borne Infectious Diseases
_____ CPR Policy
_____ Treatment of Patients with TB
_____ Substance Abuse Policy
_____ Classroom, Laboratory Safety Regulations
_____ Emergency Preparedness
_____ Accident Reporting Procedures
_____ Quality Assurance

I agree to abide by all the rules, policies, and procedures of the program. I am also aware that this handbook is intended as a guide and that policies and procedures described herein may be changed without notice. I have had the opportunity have my questions answered prior to my signing this agreement.

I have read, signed and submitted the following documents

____ Vaccination / Declaration and Declination Form

____ Confidentiality of Patient and Patient/Student Externship/Internship Information
____ Release Authorization to use Physical Likeness

____ Infectious Disease Policy

____ Informed Consent

____ Structure of Clinical Education Agreement

____ *Physician's Awareness of Pregnancy & Pregnancy Policies & Radiography (to be completed and turned in if applicable during enrollment in dental assisting or dental hygiene programs)

This form must be signed and returned on the first day of class.

_____ _____ _____
Student Signature Date Print Name

_____ _____ _____
Witness Signature Date Print Name

Must Be Completed and Turned in on the First Day of Class

Santa Rosa Junior College Health Sciences Department

Dental Programs Health Evaluation Form

_____
Program Name

STUDENT NAME:_____
Last First

BIRTHDATE:_____ STUDENT ID. # _____ GENDER: ☐ **M** ☐ **F**

ADDRESS:_____
Street City State Zip Code

PHONE NUMBER: (_____) _____-_____ **PROGRAM ENTRY DATE**:_____

E-MAIL ADDRESS_____

IN CASE OF EMERGENCY NOTIFY:_____
Name Phone

STUDENT WILL FILL IN ABOVE INFORMATION

Failure to submit completed Health Evaluation Form, immunization documentation and other program requirements by the due date, will prevent you from attending x-ray or clinical classes.

It is the student's responsibility to maintain copies of all documents submitted with applications. The Health Sciences Department ***does not*** make copies for students or provide copies of documents submitted. All Health documents are shredded after the student completes the program or is no longer in attendance.

TO THE EXAMINING PHYSICIAN OR NURSE PRACTITIONER:

Santa Rosa Junior College is interested in the health and welfare of all its students, and we particularly wish to assist each student in evaluating his/her ability to meet the physical and psychological demands of this program, in both the classroom and the clinic setting. In that interest, please provide your evaluation of this student's current health status.

(Health evaluation must be completed within the last year.) Examination may be conducted and certified by a Nurse Practitioner.

1501 Mendocino Avenue, Santa Rosa, CA 95401-4395 * (707) 527-4271 * Fax (707) 527-4426
Sonoma Count Junior College District * www.santarosa.edu

TECHNICAL STANDARDS

The curriculum leading to the Associate Degree in Dental Hygiene and the Certificate of Completion in Dental Assisting requires students to engage in diverse, complex and specific experiences essential to the acquisition and practice of essential dental hygiene/assisting skills and functions. Students in the Dental Programs should possess sufficient physical, motor, intellectual, emotional and social/communication skills to provide for patient care and safety, and the utilization of equipment.

Becoming an RDH/RDA requires the completion of an educational program that is both intellectually and physically challenging. In order to be successful in completing the requirement for these programs, students must be able to fully participate in both the academic and clinical environments. Full participation in the academic and clinical environments requires that students possess certain technical standards. Examples of these are listed below.

Technical Standards for the Dental Programs (dental hygiene and dental assisting)

Issue	**Standard**	**Examples**
Critical Thinking	Critical thinking sufficient for clinical judgment.	Take and interpret medical histories and radiographs, develop treatment plans, and react to medical emergencies.
Interpersonal	Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds.	Provide oral hygiene/oral health care instruction to patient/parents. Explain information consent and treatment plans and establish good patient rapport.
Communication	Communication abilities sufficient for interaction with others in verbal and written form.	Communication during the delivery of oral health care services, document procedures and consult with other health care providers.
Action	Ability to move from room to room and retrieve items from small spaces, as well as ability to be present at a work station for several hours at a time.	Work with a patient for prolonged periods of time and seat and/or assist in the transfer of a patient. Retrieve instruments/equipment to and from sterilization. Accompany patient to X-ray; take x-rays and process and retrieve films.
	• abilities sufficient to provide safe and effective oral health care.	Perform expanded functions, debridement, root planing and x-rays.

• abilities sufficient to monitor and assess health needs.	Assess medically compromised/medical emergencies; detect indicator tones (curing light units and x-ray units); communicate with patient/parent.
• ~~a~~bilities sufficient for observation and assessment necessary in oral health care.	Read, record in patient charts, evaluate tissue, write tissue descriptions, assess and evaluate the oral health needs of the patient.
• abilities sufficient for physical assessment.	Palpate tissue, detect restorations, calculus and evaluate debridement.

The Dental Programs are committed to ensuring that otherwise qualified students with disabilities are given reasonable accommodations. Student with disabilities who wish to request these accommodations are encouraged to contact the Disability Resources Department (DRD) to determine eligibility for services prior to the start of the program.
While the process can be initiated at any time, reasonable accommodations cannot be implemented until eligibility has been formally established with DRD.

Degrees of ability vary widely among individuals; the Dental Programs is committed to creating access to qualified individual with a disability using a case-by-case analysis. The program remains flexible with regard to the types of reasonable accommodations that can be made in the classroom and clinical settings. Student with disabilities are invited to offer suggestions for accommodation that have worked in the past. Accommodations made will specifically address the limitations associated with the student's disability.
Our belief is that accommodation should be tailored to individual situations. The process for determining the type of reasonable accommodation in the clinical setting shall be determined by the Disability Resource Department and the Dental Programs Director.

*** I have read and understood the technical standards. _____ (initials)**

Santa Rosa Junior College Health Sciences Department

REPORT OF PHYSICAL EXAMINATION

My signature below indicates that I have performed a complete history and physical examination on _____(name), a student admitted to the Dental Hygiene or Dental Assisting Program (circle one).

In my opinion, the student:

_____ Meets the Physical and mental requirements listed on the foregoing Technical Standards page

_____ Can meet the physical and mental requirements listed with reasonable accommodation.

Signature _____ Date _____

MD or NP

Address _____

Phone number _____

(Office stamp here)

REASONABLE ACCOMMODATIONS

Reasonable accommodations are modifications or adjustments that enable a qualified individual with a disability to perform the technical standards involved in a Health Sciences program. These accommodations may involve modification of the learning environment, changes in the manner or circumstances in which learning activities are performed, and/or changes that enable a qualified individual with a disability to enjoy equal benefits and privileges of participation in a Health Sciences program.

Please indicate below whether you require or do not require any reasonable accommodation[s] connected with any aspect of the program to which you have been admitted.

Based on my review of the *SRJC Health Sciences Health Requirements and Technical Standards (initial **one** of the statements below):*

_____ I can meet the technical standards with reasonable accommodations. I will make an appointment with the SRJC Disabled Student Resource Center for evaluation of accommodation needs while in the Health Sciences program. See guidelines at: http://drd/santarosa.edu.

_____ I have read the technical standards. To my knowledge, I can meet the technical standards without limitations or need for reasonable accommodation.

_____	_____
Print Name	Date
_____	_____
Signature	Date

Description of accommodation if needed:

Santa Rosa Junior College Health Sciences Department

Attach photocopies of immunization records or serology results for the following:

Students must submit photocopies of documents of immunization or verified immunity (positive serology test) to the following.			
	Dates Completed		
	Immunized		***Or* Positive Serology**
Rubella*	#1	#2	
Rubeola*	#1	#2	
Mumps *	#1	#2	
Varicella	#1	#2	
Tdap booster (every 10 years)			

All students must be immunized for Hepatitis B. If the immunization series is complete, have serology to determine immunity no sooner than 1-2 months after the third immunization. If not immune, contact health care provider to have another series of three immunizations.	
	Dates
Hep B 1	
Hep B 2	
Hep B 3	
Hep B surface antibody serology	
PPD (annual requirement) **	#1 #2
If positive, complete the Tuberculosis Clearance Form (available in Health Sci. office) & bring copy of chest x-ray report to H.S. office for file.	
Flu Vaccination (annual requirement) ***	
CPR (Basic Life Support (BLS), adult, child, infant, plus AED) Must be American Heart Association or American Red Cross approved classes	

* Combined MMR is acceptable.
* * PPD for health professionals - two-step process for the first PPD and annually thereafter
*** Flu vaccination must be current by the last day of October 2020 and annually thereafter

- Photocopies of All completed Immunization Records
- Copy of Healthcare Provider/BLS CPR card

_ go in place of this page

Hello and Welcome Dental Programs Student!

We have assigned you this locker for your use during your enrollment in the program. You must provide a combination lock (no key locks are allowed) on the first day of class (Monday, August 17th).

You will be required to provide us with the combination number to your lock on the first day of class. **Please do not leave valuables in your locker.**
For your records: Locker # _____ Combination lock #_____

For Department Records:

COMBINATION LOCK – August 17, 2020

Student Name(Print clearly):_____ My Locker # _____

Please Circle: Dental Hygiene Dental Assisting

Combination Number to your lock_____
I understand that a Department representative may enter my locker at any time for any reason and that I am responsible for thoroughly cleaning my locker when I leave the program.

Student Signature _____