

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City State Zip

I agree that the information on this form will be released to the College of Marin Dental Assisting Program, hospitals, and community agencies where students are placed.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_ email \_\_\_\_\_

This student has been accepted to a 10 month or 19 month Registered Dental Assisting Program. Students must be able to provide direct patient care in a dental setting which involves observation (use of senses to assess patients); communication (speech, reading, writing); motor skills (lifting and moving patients, standing on their feet for 8 hours per day, performing psychomotor skills); intellectual/conceptual (ability to problem solve); behavioral/social (emotional stability) and caring for patients with multiple illnesses.

**Physician's Report** All of the following information is to be completed by a Physician or Nurse Practitioner

I have reviewed the patient's history and performed a physical and/or psychiatric examination of this patient and find that his applicant:  
\_\_\_\_\_ is in good health and has no condition (physical, mental, emotional) which will limit his/her functioning in the nursing program.  
\_\_\_\_\_ is unable to perform the required duties safely.  
\_\_\_\_\_ requires further evaluation for clearance (Psychiatric, orthopedic, neurologic, etc) type of referral

The following tests, vaccination, or immunizations are required and should be current\*

**PROOF BY TITER OR VACCINE ONLY - VERBAL HISTORY NOT ACCEPTABLE**

|  |   |  |  |   |  |
|--|---|--|--|---|--|
| <b>Tuberculin (PPD)</b><br>(2 tests- 1 week apart)<br>or Chest X-ray | 1 <sup>st</sup> test Date: _____<br>2 <sup>nd</sup> test Date: _____<br>Date: _____ | Results: _____<br>Results: _____<br>Results: _____ | <b>Current Tdap (within 10 years)</b><br>Date: _____   | <b>Influenza Vaccine</b><br>Date: _____ or<br>Declination form on file: _____ |  |
| <b>MMR #1</b><br>Date: _____   | <b>MMR #2</b><br>Date: _____  | or Titters ►                                       | <b>Rubeola titer:</b><br>Date: _____<br>Results: _____ | <b>Mumps titer:</b><br>Date: _____<br>Results: _____                          | <b>Rubella titer:</b><br>Date: _____<br>Results: _____ |
| <b>Varicella #1</b><br>Date: _____                                   | <b>Varicella #2</b><br>Date: _____  |  | <b>Varicella titer:</b> Date: _____<br>Results: _____  |   |  |
| <b>Hepatitis B</b><br>Dates: #1 _____ #2 _____ #3 _____              |   |  | <b>Hepatitis titer:</b> Date: _____ Results _____      |   |  |

Date of most recent physical exam: \_\_\_\_\_

Address \_\_\_\_\_  
City State Zip

Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature of medical provider

\_\_\_\_\_  
Print or type name of medical provider

**Note: All data on this form must be completed.**

Proof of an **annual two-step** skin test (intradermal PPD) must be on file with the School and must show the date of the test and the results. Proof shall be furnished on a physician's letterhead, Lab form, or a form with a physician's (or person authorized by a physician) signature. **PPD must be dated on or after June 1, 2019. PPD MUST BE DONE PRIOR TO any MMR AND VARICELLA vaccines.**

If the student is known to be PPD positive (skin test positive for tuberculosis), a written statement from a physician verifying a recent negative chest x-ray (within one year of entry into the program) and completion of a Tuberculosis Questionnaire is required. Thereafter, the student is required to complete, on an annual basis, the Tuberculosis Health Questionnaire.

Lab tests showing proof of antibodies or immunity to Rubella, Rubeola, Mumps and Varicella (depending on placement) or vaccinations must be on file with the school. Rubeola and Mumps require two (2) doses with second dose at least one month after the first. Varicella Zoster requires two (2) doses. Rubella requires one (1) dose. **Varicella must be verified by documentation of immunization or titer – verbal history not accepted.**

A verified tdap must be on file with appropriate, if any, DT or TD booster given every ten years, thereafter, and that date to be on file with the school.

Hepatitis B vaccination is required and may not be waived. Please check with the College of Marin Health Center about the series at a reduced fee - 415.485.9458 The College will provide a Bloodborne Pathogen training program to reduce exposure to blood and other infectious materials.

The College of Marin Health Center offers Physical Exams, MMR, tdap, hep B and tb tests; Blood Titers may be available - depending on which titer is needed.