



Dental Hygiene

Name: _____
CTC Link ID: _____
Cell Number: _____
Shoreline Email: _____
Return this form to: gomalley2@shoreline.edu
Due Date: _____

Health Assessment Report

All students participating in learning experiences at Shoreline Dental Hygiene Program must meet the following health and safety requirements.

Students are responsible for their own medical expenses. If it is necessary for the student to get medical care of any kind, including Emergency Room treatment due to an injury sustained while participating in clinical, the student will be responsible for any charges incurred. A student health insurance policy is available through Shoreline Community College and may be purchased at the time of registration.

All clinical students are expected to meet the health standards of any dental employee. A physical exam, TB screening test, Tdap, MMR, Varicella, and COVID-19 vaccine are required for all Dental Hygiene Program students entering the program and before being allowed in the clinical setting. Completion of the Hepatitis B vaccination series is mandated prior to starting clinical sessions. TB screening is required annually, prior to the start of the fall quarter

Part 1. IMMUNIZATION/COMMUNICABLE DISEASE RECORD—Proof of record required

****You must submit Immunization documentation/records that include your name and date of birth, and date of immunization with this form****

Immunization	Date of Immunizations	Provider Name
Hepatitis B—3 dose series OR positive Titer showing immunity	Vaccination Dates 1. 2. 3. OR Immunity by Titer Date:	1. 2. 3. 1.
MMR (Measles, Mumps, Rubella) 2 does series OR positive Titer showing immunity	Vaccination Dates 1. 2. OR Immunity by Titer Date:	1. 2. 1.
TDaP (Tetanus, Diphteria, Pertussis)— within the last 10 years	Date:	
Varicella (Chicken Pox)	Vaccination Dates: 1. 2. Or Immunity by Titer Date:	1. 2. 1.

Covid-19 Vaccine	Vaccine Information Date of 1st dose: Date of 2nd dose: Manufacturer: 1 or 2 dose series:	Covid- 19 Booster—Although a covid booster dose is not required at this time, it may be required in the future and for some extramural sites. Vaccine Information: Manufacturer: Date: Manufacturer: Date:
Influenza—1 dose during Flu season—September to June	Date: Date: Date:	Which healthcare provider administered vaccine?
TB Skin Tests—Required each year	Annual TST (skin test): Date: Result Neg: ☐ Pos: ☐ mm: OR Annual TB IGRA (blood test) Date: Result:	
NOTE: If you have or have had a positive PPD test, a chest x-ray is required to demonstrate no active Tuberculosis. Those with a positive PPD must sign a yearly screening form that testifies that they have had no tuberculosis symptoms since their last Chest X-Ray. Once the student has a positive PPD skin test, no further skin tests are done since once positive, always positive.	If new positive TST or IGRA Exam/Chest X-ray Exam Date: X-ray Date: Result:	For known Positive/Possible Treatment: Complete symptom check Type of treatment: Date:

Part 2. HEALTH HISTORY

1. Date of last physical exam:
2. List all present diseases, injuries, disabilities, etc:
 1.
 2.
 3.
 4.
 5.

Give the approximate date of onset if appropriate and any details needed for clarification:

3. Do you have any history of the following conditions, which could affect intra-oral procedures being performed on you?
 - ☐ Heart murmur
 - ☐ Congenital heart defect
 - ☐ Mitral valve prolapse
 - ☐ Prosthetic joints
 - ☐ Other. Please describe
4. Are you currently under treatment or taking any medications for any physical or emotional illness?
 - ☐ Yes ☐ No

5. List all drugs or medications you use frequently or regularly.

1.
2.
3.
4.
5.

6. Do you have a hearing deficit?

☐ No

☐ Yes. Is it corrected? Yes ☐ No ☐

Date of last exam

7. Do you have any visual deficit?

☐ No

☐ Yes. Is it corrected? Yes ☐ No ☐

Date of last exam

8. Other health information you believe is pertinent to share.

I certify that the above information is accurate:

Signature _____

Date: _____