
Oulton College requires completion of this information package prior to commencing the program of any calendar year in order to ensure that health and safety measures for our students and staff are met.

Please complete and return to admissions before: August 2010

1. Medical Examination Form

Required from attending physician as proof that the student does not have any medical condition that would affect their dental health or require pre-medication before any treatment. You will be practicing actual procedures on each other.

2. Confidentiality statement and Confirmation of Observation

As part of your admissions acceptance to ensure that as a potential student, you understand the dental field and the duties you will be licensed to perform

3. Immunization report

It is mandatory that each student is immunized for tetanus and Hepatitis B, or complete documentation of declination for their file. If, for medical reasons, you are unable to be vaccinated, please provide a note stating so from your attending physician. TB is not a mandatory vaccine, but can be obtained through the Chest clinic at your local hospital. Hepatitis and Tetanus vaccines can be obtained from your family physician or VON (506) 857- 9115.

4. Dental Form

You will be practicing and performing several dental procedures on each other throughout the year, therefore regular dental and dental hygiene appointments to ensure good dental health are important. Any outstanding restorative treatment should be scheduled for completion. Please have the attached form completed by your dentist.

5. Proof of Certification

CPR level C and Standard First Aid certifications are required before registration. They must be valid until the completion of the program.

6. Criminal Record Check

Many offices and community agencies that you will be involved with throughout the program require you to have completed a criminal record check with no convictions.

Upon completion of the attached information, please submit to Oulton College administration.



Since • Depuis 1956

Medical Examination Form
Dental Hygiene Program
2010-2011

TO THE PHYSICIAN: Oulton College requires a health history of any student enrolling in a health program. A brief report of any information that you may have on this student's health would be appreciated. This information will go directly to Admissions and will be released only to the authorized college and clinical facilities personnel.

DISCLOSURE AND CERTIFICATION STATEMENTS

I hereby grant permission for the release/disclosure of health screening medical information between and among authorized college, clinical facilities and hospital personnel.

Applicant's Name: _____ Signature _____

Date _____

To be completed by your attending physician

Health History – to be completed by student	Circle "YES" or "NO"	
1. Have you ever been hospitalized?	Yes	No
a. List health problem	Date:	
b. List operations performed	Date(s):	
2. Are you under the physician's care now?	Yes	No
a. List name of personal M.D.		
b. List health problems		
c. Are you taking medications on a regular basis?	Yes	No
List:		
3. Do you have any allergies?	Yes	No
List medication you are allergic to:		
List other allergies (food, pollen, contact, animal, dust):		
4. a. Have you had a back or neck or wrist injury?	Yes	No
b. Have you had an injury to any muscle, bone, ligament or tendon?	Yes	No
PLEASE INDICATE IF YOU OR A FAMILY MEMBER HAVE HAD:	SELF	FAMILY MEMBER
a. Hypertension (High blood pressure)		
b. Heart disease		
c. Diabetes		
d. Tuberculosis		
e. Seizure disorder		
f. Asthma		

STUDENT'S NAME _____
(PRINT) Last First Initial

Mark the appropriate box below:

- From findings on this health history, I certify that this student is in good health and can participate in the Dental Hygiene clinical program.
- This student requires pre-med before dental treatment.
- The candidate health problems(s) should be further evaluated **PRIOR** to participation in a clinical assignment:

Physician's signature _____

PART A - CONFIDENTIALITY STATEMENT

As a student applying for the Dental Hygiene program at Oulton College, I agree to hold all clientele records, treatment, and conversations as confidential information. If I were to breach this confidentiality agreement in any manner I understand that I will not be considered for admission in this dental program.

Date

(Signature of student – applicant)

PART B - CONFIRMATION OF OBSERVATION

As verification that this observation has been performed as a requirement for admissions to Oulton College's Dental Hygiene program, the dentist or assistant under whom the student is being observed is asked to complete this form. Oulton College appreciates the support given by any dentist or assistant for allowing our student(s) to observe in your dental office and also for taking the time to complete this form.

(Print name of student)

The student named above has completed an observation in my office as part of the requirements for admission in the Dental Hygiene Program for a period of 4 hours (half day equivalent)

(Print name of Dentist)

(Telephone No.)

(Signature of Dentist)

(Date)

Please return this form to the address listed below or bring into admissions as soon as the observation has been completed. Questions may be directed to the Director of Dental Programs, Darcie Robichaud, at 858-8484
Thank you again for your time and support.



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Immunization Form
Dental Hygiene Program
2010-2011

Student Name: _____

1. TD (Tetanus/Diphtheria)

If already vaccinated, a booster is required every 10 years.

Date: _____

Signature of Health Care Provider: _____

2. Hepatitis A/B

Two doses of the vaccine must be complete prior to orientation and series must be complete prior to patient care. Hepatitis B or a combination A/B vaccine is acceptable. Should you be accepted to the program late, a **rapid dose immunization is also acceptable and recommended**. Please inquire with your health care provider.

Hepatitis

Dose 1 Date _____ X _____

Dose 2 Date _____ X _____

Dose 3 Date _____ X _____

3. Tuberculin Test (PPD) – Optional in New Brunswick.

Date: _____

Signature of Health Care Provider: _____



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Dental Examination Form
 Dental Hygiene Program
 2010-2011

This is to certify that (student name) _____.

Saw me for an examination of her (his) teeth on (date) _____.

Follow – up treatment required:

During the upcoming academic year (s), the student named above will participate in educational clinics- where students will be practicing intra oral procedures on one another. Based on your examination today, do you agree to the following as part of the dental program education?

<input type="checkbox"/> Y <input type="checkbox"/> N	Are there any posterior teeth, other than those mentioned above that are not suitable for pit and fissure sealants. NOTE- surfaces will be rechecked by dental faculty prior to sealing.	List teeth not to be sealed:	
The student will be required to participate in live radiographic experiences for educational purposes. Duplicates of any film taken on the student will be forwarded to your office. Please provide a brief history for reference.		Date of students last Bite Wings:	Date and view of other films in last 2 years:

 Dentist (Please Print)

 Signature

 Date

Student Name: _____

Please attach a photocopy of your CPR Level “C” and Standard First Aid certifications

***letter from the company that provided your training is also acceptable until certificate is issued.**

- Standard First Aid certification is valid until: _____
- CPR Level “C” certification is valid until: _____