INSTRUCTIONS FOR COMPLETING
STUDENT HEALTH AND IMMUNIZATION RECORD

Health and Public Services Department students need to complete and submit the Student Health and Immunization Record when beginning their program. The form must be completed with health care provider (HPC) verification of current immunization, conditions requiring treatment, and/or special accommodation needs. Complete documentation is necessary for assigning students to cooperating agencies for the practice component of the program. Program continuation requires each student to preform every essential function of the student role. If the student, with reasonable accommodations, is unable to perform any essential function in a safe and successful manner, he/she will be required to withdraw from the program.

HEPATITIS B, CHICKENPOX AND PERTUSSIS (Tdap) IMMUNIZATIONS:
Des Moines Area Community College requires incoming students in Dental Assisting, Dental Hygiene, Early Childhood Education, Medical Assisting, Medical Lab Technology, Nursing, Pharmacy Tech, Phlebotomy, Respiratory Therapy and Surgical Technology to be vaccinated or have titers as evidence of immunity to Hepatitis B. Aging Service Management students are exempt from the HEP B requirement. All students must show proof of immunity to Chickenpox and documentation of current vaccination to tetanus, diphtheria and pertussis. If proving immunity by titers, lab reports documenting each titer must be attached to the form. Please read the vaccine information sheets available from the Center for Disease Control (CDC) at http://www.immunize.org/vis/ to learn the advantages and contraindications for Tdap, Chickenpox, Hepatitis B, and MMR. For TB testing information: http://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm

WHERE TO GET IMMUNIZED
If you are currently working in a health care facility, check with your employer to see if the TB test and vaccines are offered free of charge. Some insurance companies will cover the cost of the vaccines or titers (blood tests). If your insurance company will not cover the cost of the vaccination or titers, you will be responsible to cover the cost. Immunizations can be arranged through your private physician, County Health Department or the Ankeny campus nurse. As you undergo immunization, it is very important not to miss an injection. If you cannot have an immunization, a medical waiver form must be completed and signed by your physician and accompany your immunization form. See your Program Chair for a waiver form.

Completed forms and any supporting documents (lab titers) are to be uploaded to your https://www.viewpointscreening.com/ account

**NO LATER THAN THE FIRST DAY OF THE TERM.** Immunization records are required for most health care positions.

Make a copy of this completed form for future job applications.

<table>
<thead>
<tr>
<th>Questions about completing the form?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact your program chair or the program coordinator:</td>
</tr>
<tr>
<td>Jackie Kollasch RDH, MS, CDA</td>
</tr>
<tr>
<td>Dental Programs Chair</td>
</tr>
<tr>
<td>Ankeny Campus, Bldg 9, Rm 4</td>
</tr>
<tr>
<td>(515) 964-6582, (800) 362-2127 X.6592</td>
</tr>
<tr>
<td><a href="mailto:jskollasch@dmacc.edu">jskollasch@dmacc.edu</a></td>
</tr>
<tr>
<td>Julie Benson</td>
</tr>
<tr>
<td>Administrative Assistant 2</td>
</tr>
<tr>
<td>Ankeny Campus, Bldg 9, Rm 2A</td>
</tr>
<tr>
<td>(515) 964-6371 (800) 362-2127 x.6371</td>
</tr>
<tr>
<td><a href="mailto:jrbenson@dmacc.edu">jrbenson@dmacc.edu</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Questions about uploading the form or Viewpoint contact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viewpointscreening.com</td>
</tr>
<tr>
<td>Email Questions to:</td>
</tr>
<tr>
<td><a href="mailto:Studentsupport@viewpointscreening.com">Studentsupport@viewpointscreening.com</a></td>
</tr>
<tr>
<td>Chat function recommended M-F 9AM-5PM EST</td>
</tr>
</tbody>
</table>
Health and Immunization Record

Incomplete forms will not be accepted!

Before uploading your forms to ViewPoint, look it over carefully to confirm that:

- There are no blank lines or missing signatures
- All sections (Part I, II, and III) are completed
- Information about health insurance is listed or “none” is indicated (be sure to include insurance provider and your account number)
- Someone is identified for emergency notification if you are seriously ill or injured
- Dates of your last physical and dental exams are listed
- Allergies to medications or other substances are listed or you have put “none known”
- You signed and dated the bottom of Part I
- Your health care provider is completed, dated and signed the bottom of Part II
- Correct information is listed for each immunization or screening in Part III. Read the instructions for each item carefully
- Your health care provider signed the bottom of Part III
- If you are using titers to show evidence of immunity, you must attach copies of laboratory tests for each titer
- Scan your “Student Health and Immunization Record” form and save it as a PDF on your computer
- DMACC Library or the Dental Clinic has scanners available for student use

Put your original completed forms in a safe place. You may also want to save your completed and scanned forms in more than one place. When you get a new job any health care employer will ask you to provide documentation of your immunizations
HEALTH AND PUBLIC SERVICES DEPARTMENT
STUDENT HEALTH AND IMMUNIZATION RECORD

Program in which you are enrolling: ____________________________ Campus: ________________

All students enrolling in the health and early childhood programs must complete Part I of this form before consulting with a health care provider (MD/DO, PA, NP) to verify dates of immunizations and treatment of current or chronic conditions. With the exception of immunization information or in the case of medical emergencies, no information will be released to anyone other than the Health and Public Service Department without consent of the student.

Program continuation requires each student to perform every essential function of the student role. If the student, with reasonable accommodation, is unable to perform any essential function in a safe and successful manner, they will be required to withdraw from the program.

**PART I: BACKGROUND INFORMATION** To be completed by student. *(Please Print)*

A. **PERSONAL DATA**

<table>
<thead>
<tr>
<th>Gender</th>
<th>DMACC ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Male</td>
<td>900</td>
</tr>
<tr>
<td>☐ Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address (Number and Street)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone: Home</th>
<th>Work</th>
<th>Health Insurance Company/Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>In Case of Emergency, Notify: Name</th>
<th>Relationship</th>
<th>Home Phone</th>
<th>Work Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

B. **PERSONAL HEALTH HISTORY**

DATE OF MOST RECENT DENTAL EXAM

month year

**ALLERGIES:** If none, write below None Known

Medication: __________________________________________________________

Other Types: _________________________________________________________

I have the following “Med-alert” condition: ____________________________

OTHER COMMENTS:

__________________________________________

Student Signature Date
PART II: MEDICAL HISTORY

Student Name ________________________________

1. Physical/mental conditions which have required treatment within the last 6 months or are chronic in nature:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

2. Medications taken currently or routinely:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

3. Conditions which restrict activity and/or require special adaptation(s):

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

4. Other:

__________________________________________________________________________
__________________________________________________________________________

5. Core Performance Standards:

Please refer to the attached Iowa Core Performance Standards for Health Career Programs and indicate if the above named individual may have difficulty meeting any of the eleven standards outlined.

At this time this individual is capable of meeting the performance standards:

___ Agree

___ Disagree. The following limitations are present ________________________________________________

___ Additional evaluation suggested ____________________________________________________________

6. Date of Last Physical Exam: ____________________
   (within one year of program entry) mm/dd/yr

_________________________________________  ________________________________
Date                  Signature of Health Care Provider    (MD, DO, ARNP, PA)
Iowa Core Performance Standards for Health Care Career Programs

Iowa Community Colleges have developed the following Core Performance Standards for all applicants to Health Care Career Programs. These standards are based upon required abilities that are compatible with effective performance in health care careers. Applicants unable to meet the Core Performance Standards are responsible for discussing the possibility of reasonable accommodations with the designated institutional office. Before final admission into a health career program, applicants are responsible for providing medical and other documentation related to any disability and the appropriate accommodations needed to meet the Core Performance Standards. These materials must be submitted in accordance with the institution’s ADA policy.

<table>
<thead>
<tr>
<th>Capability</th>
<th>Standard</th>
<th>Some Examples of Necessary Activities (Not All Inclusive)</th>
</tr>
</thead>
</table>
| Cognitive-Perception| The ability to perceive events realistically, to think clearly and rationally, and to function appropriately in routine and stressful situations. | • Identify changes in patient/client health status  
• Handle multiple priorities in stressful situations |
| Critical Thinking   | Critical thinking ability sufficient for sound clinical judgment situations | • Identify cause-effect relationships in clinical  
• Develop plans of care |
| Interpersonal       | Interpersonal abilities sufficient to interact appropriately with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds | • Establish rapport with patients/clients and colleagues  
• Demonstrate high degree of patience  
• Manage a variety of patient/client expressions (anger, fear, hostility) in a calm manner |
| Communication       | Communication abilities in English sufficient for appropriate interaction with others in verbal and written form. | • Read, understand, write, and speak English competently  
• Explain treatment procedures  
• Initiate health teaching  
• Document patient/client responses  
• Validate responses/messages with others |
| Mobility            | Ambulatory capability to sufficiently maintain a center of gravity when met with an opposing force as in lifting, supporting, and/or transferring a patient/client. | • The ability to propel wheelchairs, stretchers, etc., alone or with assistance as available |
| Motor Skills        | Gross and fine motor abilities sufficient to provide safe and effective care and documentation. | • Position patients/clients  
• Reach, manipulate, and operate equipment, instruments, and supplies  
• Electronic documentation/keyboarding  
• Lift, carry, push, and pull  
• Perform CPR |
| Hearing             | Auditory ability sufficient to monitor and assess, or document health needs. | • Hears monitor alarms, emergency signals, auscultatory sounds, cries for help  
• Hears telephone interactions/dictation |
| Visual              | Visual ability sufficient for observation and assessment necessary in patient/client care, accurate color discrimination. | • Observes patient/client responses  
• Discriminates color changes  
• Accurately reads measurement on patient/client related equipment |
| Tactile             | Tactile ability sufficient for physical assessment, inclusive of size, shape, temperature, and texture. | • Performs palpation  
• Performs functions of physical examination and/or those related to therapeutic intervention, e.g., insertion of a catheter |
| Activity Tolerance  | The ability to tolerate lengthy periods of physical activity. | • Move quickly and/or continuously  
• Tolerate long periods of standing and/or sitting |
|                     | Ability to tolerate environmental stressors | • Adapt to rotating shifts  
• Work with chemicals and detergents  
• Tolerate exposure to fumes and odors  
• Work in areas that are close and crowded  
• Work in areas of potential physical violence |
**Part III**

Name_______________________________ DMACC ID _________________ Due date: _____

### Required Test and/or Immunizations

This form is to be completed, signed and dated by a licensed health care provider (MD, DO, ARNP, PA). Take your immunization records and documentation of disease with you to your appointment. If immunization records are not available, the HCP will determine what vaccinations tests or titers are indicated. **Documentation of the items below are required by the clinical agencies DMACC contracts with for clinical/internship experience.**

<table>
<thead>
<tr>
<th>Test/Immunization</th>
<th>Date Admin mm/dd/yy</th>
<th>Date Read mm/dd/yy</th>
<th>Results: mm of induration</th>
<th>If Positive PPD, Chest X-ray mm/dd/yy</th>
<th>CXR Results</th>
<th>Is treatment plan indicated? Check one</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TB Skin Test</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Yes-attach □ No</td>
</tr>
</tbody>
</table>
| Must be PPD by Mantoux (Not Tine) within the last 12 months prior to 1st internship
| 1st TB (required)-or lab test verifying no disease-verify insurance coverage |
| 2nd TB **(HIT:2nd TB test may be required later for students assigned to internship site where a 2-step method is mandatory)** |
| **Adult Diphtheria/Tetanus/Pertussis**                  |                      |                    |                           |                                        |             | □ Yes-attach □ No                       |
| All healthcare personnel (HCP) who have not or are unsure if they have previously received a dose of Tdap should receive a one-time dose of Tdap as soon as feasible, without regard to the interval since the previous dose of Td. Then, they should receive Td boosters every 10 years thereafter. |
| HCP Vaccination Recommendations Centers for Disease Control and Prevention, March 2011. |
| **Varicella** (Chicken Pox)                            |                      |                    |                           |                                        |             | □ Yes-attach □ No                       |
| Evidence of immunity includes any one of the following:
| Positive titer
| Two doses of vaccine
| Documentation by HCP of chickenpox or herpes zoster. **Verbal history is not acceptable** |
| **MMR**                                                |                      |                    |                           |                                        |             | □ Yes-attach □ No                       |
| All students (regardless of age) must have documentation of either 2 MMR vaccinations
| Documentation of sufficient titers for Rubeola, Mumps and Rubella. Those who have an “indeterminate” or “equivocal” level of immunity upon testing should be considered non-immune. Lab results of titers must be attached to this form. |

I certify this student has received the TB test and immunizations as indicated above or has laboratory evidence of immunity which is attached to this form.

_______________________________________________
Print Name of Health Care Provider

_______________________________________________
Signature of Health Care Provider (MD, DO, ARNP, PA)

<table>
<thead>
<tr>
<th>Address of Health Care Provider</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>(__<strong><strong>)</strong></strong>________________</td>
<td></td>
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</table>
Policy Acceptance Form

This is to verify that I have reviewed the DMACC Dental Hygiene Program Student Handbook and course policies (in PowerPoint format) on (date) _________________________ and I clearly understand the policies contained in each section. I hereby agree to abide by these policies and will follow all requirements as long as I am a student in this program. I understand the consequences if I do not abide by these policies. I have had adequate time to be able to ask questions regarding this handbook and have all policies clarified.

Please initial each section:

_____ Philosophy
_____ Competencies
_____ Being Exceptional
_____ Personal and Professional Accountability
_____ Program Information Brief
_____ Skills and Abilities
_____ Student Organizations
_____ Academic Standards
_____ Testing Policies
_____ Grading
_____ Enrollment status
_____ Licensure
_____ Graduation/ Job References
_____ Student Rights and Responsibilities
_____ Physical, mental, and behavioral requirements
_____ HIPAA policy and acknowledgement
_____ Student Conduct/ Code of Ethics
_____ Academic Integrity/ Standards & Probation
_____ Grooming/ Professional Appearance
_____ Attendance, Classroom & Lab Management Policy
_____ Exposure Incidents
_____ Student Services/ Student Health
_____ Social Media Policy
_____ Scholarships
_____ Background checks and Health forms

Student printed name: ______________________________________________________________

Student signature: _________________________ Date: __________________
Policy Acceptance Form

Please sign and date this form. It is DUE on or before the first day of the term.

Return completed form to:

Jackie Kollasch, RDH, MS, CDA
DMACC Dental Hygiene Program Chair 2006 S. Ankeny Blvd., Bldg. 9-4
Ankeny, IA 50023
jskollasch@dmacc.edu

I certify that I have read and understand the Des Moines Area Community College Dental Hygiene Student Policy Manual.

______________________________  _________________________
Signature                                  Date

______________________________
Printed or Typed Name