

**Continuing Education Program  
Dental Assistant Level II Upgrade Certificate  
(DENT 9206) Intraoral 1-Theory and Concepts Course**

**Requisite health form deadline:** \_\_\_\_\_ (one month prior to the first day of class per semester)

**REQUISITE HEALTH FORM CHECKLIST**

**Notice:** Upon your **acceptance** in this course, it is your **main responsibility** to start and meet all the medical & additional requirements outlined below. This process will take **10 to 12 weeks** to complete and it must be submitted to ParaMed Office by the given deadline. If you **fail** to do so, you will be **excluded** from dental practice which will **affect** your academic standing & may lead to program **withdrawal**. All costs, service fees and fine associated with the overall health form requirements are responsibility of the student.

**MEDICAL REQUIREMENTS**

Book an appointment with your doctor/Walk-In Clinic. Bring this health form to your appointment and advise your doctor to sign and stamp your health form documents upon completion of all medical requirements. **Please read all detail instructions on pgs. 2 & 3**

- Tetanus, Diphtheria & Pertussis (Tdap/Adacel/Boostrix vaccine must be valid every 10 years) attach yellow card/immunization record **pg. 2**
- Seasonal Flu Shot (recommended every November or December) **pg. 2**
- Measles, Mumps & Rubella (MMR) (ask your doctor for blood work and ATTACH copies of your laboratory blood test reports and all immunization records on the form. It may require two or more doctor's appointments and up to six weeks to get your results) **pg. 2**
- Varicella (Chicken Pox) (ask your doctor for blood work and ATTACH copy of your laboratory blood test report and all immunization records on the form. It may require two or more doctor's appointments and up to six weeks to get your results, fees may apply) **pg. 2**
- Hepatitis B (ask your doctor for blood work and ATTACH a copy of laboratory blood test report. If you had proof of immunization or doses in the past, ask the doctor to document it on your forms. If it was a recent/new dose, get the following doses as outlined and maximum of six Hep B doses in a lifetime) **pg. 3**
- Two Consecutive Step-Tuberculosis Skin Test (ATTACH documented proof of previous or current Two Step-TB Skin Test and it will require four or more doctor's appointment and fees may apply) **pg. 3**
- Final Signature of doctor/physician and Medical Office stamp, **pg. 2 & 3**
- Yellow immunization card or any type of immunization records

**ADDITIONAL REQUIREMENTS**

Please apply for your certificates below and bring all originals and one set of photocopies of your documents at your scheduled appointment with ParaMed Office. **Please read all detail instructions on pgs. 4-5**

- [CPR Level \(C\) Certificate Card](#) (renew every year) **pg. 4**
- [Mask Fit Test Certificate Card](#) (renew every two years) **pg. 4**
- [ParaMed Office](#) Appointment & Service Fees, **see below & pg. 4**
- ParaMed and George Brown College Agreement Form, **pg. 5**

**PARAMED OFFICE APPOINTMENT & SERVICE FEES (rates are subject to change)**

**Notice:** Once you have everything done and registered to this course, your **final step** is to **create an account and book an appointment** with ParaMed Office online at [www.georgebrownhealth.ca](http://www.georgebrownhealth.ca) by the given deadline. It is mandatory that you bring and submit all of the originals, one set of photocopies of your forms and pay the Service Fees at your scheduled appointment. Please **DO NOT** book or go to ParaMed Office with an **INCOMPLETE** forms, otherwise they will **charged** you a **Subsequent Visit Fee**. ParaMed is a "**Fragrance Free Zone**", kindly **do not wear** any perfume, lotion or cologne at your appointment.

**(June 1<sup>st</sup>, 2017 to May 31<sup>st</sup>, 2018)**

- Standard Visit Fee - \$55.10 dollars (submission of health form, RN fee, archives & medical records access online)
- Subsequent Visit Fee (due to a Deficiency List Form) - \$24.15 dollars
- Cancelled or Missed Appointment Fine-\$55.10 dollars (without 24 hour notice)
- Mask Fit Test-\$44.90, Photocopy - \$3.00

**CONTACT US**

- Suzette Martinuzzi, Coordinator at (416) 415-5000 ext. 3415 or via email [smartinu@georgebrown.ca](mailto:smartinu@georgebrown.ca)
- Clinical Pre-placement Office Campus Locations:
- **(Mon-Wed)** 51 Dockside Drive, Room 702, 7<sup>th</sup> Floor, Waterfront Campus
- **(Thursday-Friday)** 200 King Street East, Room 401B, 4<sup>th</sup> Floor, Building "A", St. James Campus
- Business Hours: 8:00 am to 3:30 pm, by appointment only or visit <https://coned.georgebrown.ca/continuing-education-clinical-pre-placement-health-form-requirements/>

**Continuing Education Program  
Dental Assistant Level II Upgrade Certificate  
(DENT 9206) Intraoral 1-Theory and Concepts Course  
Requisite Health Form**

NAME x \_\_\_\_\_  
 GBC ID# x \_\_\_\_\_  
 TEL x \_\_\_\_\_  
 EMAIL x \_\_\_\_\_  
 DEADLINE DATE x \_\_\_\_\_

*(ParaMed Official Stamp here)*

**MEDICAL REQUIREMENTS  
(DOCTOR/PHYSICIAN/HEALTH CARE PROFESSIONAL TO COMPLETE, SIGN & STAMP)**

Ontario legislation specifies certain surveillance requirements for those entering into healthcare practice settings. The Program policy was developed in accordance with the communicable disease surveillance protocols, specified under the Public Hospitals Act, to meet the requirements of our students' placement settings. This process is necessary to ensure that our students protect their health and safety, and the health and safety of patients, visitors, employees and other students. Other than the influenza vaccine, the completion of this information is not optional, and all sections must be completed as outlined. Our placement partners have the right to refuse students who have not met their immunization standards. If, for medical reasons, your client is unable to receive a required immunization or Chest X-ray, a medical note of this exclusion must be provided on the form.

**Note:** If you **do not** have any proof of immunization records, you must contact your doctor or your regional Public Health to obtain a copy of your old/new immunization record.

1. **TETANUS, DIPHTHERIA & PERTUSSIS (Tdap/Adacel/Boostrix vaccine must be valid every 10 years)** attach a yellow card or any immunization record

Date of last Tetanus, Diphtheria & Pertussis (Tdap/Adacel/Boostrix) booster \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

2. **SEASONAL FLU SHOT (recommended every year in November/December)**

Influenza virus vaccine is available free of charge from health services in the fall or can be obtained from your healthcare provider. Students are encouraged to submit evidence of the vaccination in December. If you know or suspect that you have an allergy to eggs or other vaccination preservatives or components, please discuss your options with your HCP. Do not worry about the flu shot at this time; you may submit your completed health form documents to ParaMed Office without the flu shot record. GBC will do a flu shot clinic in November/December. The influenza vaccine is not mandatory; however, if an outbreak occurs at an assigned agency, and flu vaccine was not received, you may be denied access to the facility, thus jeopardizing the successful completion of your placement.

Seasonal Flu Shot Given Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm / dd / yyyy) Healthcare provider signature \_\_\_\_\_

3. **MEASLES, MUMPS & RUBELLA (doctor check the appropriate box, attach a copy of lab blood test reports valid within 5 years and document all doses as outlined below)**

Immunity/Reactive blood test result (**Note:** NO injections required; ATTACH copy of most recent MMR laboratory blood test reports valid within 5 years)

Non-Reactive/Non-Immunity/Indeterminate lab test result (**Note:** ATTACH copy of most recent laboratory blood test report, get and document the following doses as outlined below; maximum of three MMR doses in a lifetime)

1st Dose Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm / dd / yyyy) (four to six weeks after 1<sup>st</sup> dose, repeat a second blood test; if result is "Non-Reactive/Indeterminate", get the 2<sup>nd</sup> dose as outlined below)

2nd Dose Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm / dd / yyyy) (four to six weeks after 2<sup>nd</sup> dose, repeat a third blood test; if result is "Non-Reactive/Indeterminate", get the 3<sup>d</sup> dose as outlined below)

3rd Dose Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm / dd / yyyy) (four to six weeks after 3<sup>d</sup> dose, repeat a fourth blood test; if result is "Non-Reactive/Indeterminate", student status will be "Non-responder/Exception")

4. **VARICELLA (CHICKEN POX) (doctor check the appropriate box, attach a copy of lab blood test reports valid within 5 years and document all doses as outlined below)**

Immunity/Reactive lab test result (**Note:** NO injections required; ATTACH copy of most recent laboratory blood test reports valid within 5 years)

Non-Reactive/Non-Immunity/ Indeterminate lab test result (**Note:** ATTACH copy of most recent laboratory blood test report, get and document the following doses as outlined below; maximum of two Varivax doses in a lifetime)

1st Dose Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm / dd / yyyy) (four weeks after 1<sup>st</sup> dose, get the 2<sup>nd</sup> dose as outlined below)

2nd Dose Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm / dd / yyyy) (six to eight weeks after 2<sup>nd</sup> dose, repeat a second blood test; if the result is "Non-Reactive/Indeterminate", student status will be "Non-responder/Exception")

Final Signature of doctor/physician/health care professional: \_\_\_\_\_ (pages 2 & 3)

Date (mm/dd/yyyy): \_\_\_\_\_ (pages 2 & 3)

Medical Office Stamp: \_\_\_\_\_ (pages 2 & 3)

NAME \_\_\_\_\_ **GBC ID#** \_\_\_\_\_

**(DENT 9206) MEDICAL REQUIREMENTS**

**5. HEPATITIS B (doctor check the appropriate box, attach a copy of lab blood test reports valid within 5 years and document all doses as outlined below)**

- Immunity/Reactive/Positive lab test result (**Note:** NO injections required; ATTACH copy of most recent "Antibody" laboratory blood test reports valid within 5 years)
- Non-Immunity/Non-Reactive/Negative/Low (>0 or <10) lab test result (**Note:** ATTACH copy of most recent "Antibody" laboratory blood test report and get the following doses. Maximum of six Hep B doses in a lifetime)
  - 1st Dose Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/ dd / yyyy) (four weeks after 1<sup>st</sup> dose and get the 2<sup>nd</sup> dose)
  - 2nd Dose Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/ dd / yyyy) (four to six weeks after 2<sup>nd</sup> dose, repeat a second blood test; if the result is "Non-Reactive/Negative" and get the 3<sup>rd</sup> dose)
  - 3rd Dose Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/ dd / yyyy) (due six months after 1<sup>st</sup> dose. Then, four weeks following 3<sup>rd</sup> dose, repeat a third blood test; if result is "Non-Reactive/Negative" and get 4<sup>th</sup> & 5<sup>th</sup> doses)
  - 4th Dose Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/ dd / yyyy) (four to six weeks after 4th dose and get a 5th dose)
  - 5th Dose Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/ dd / yyyy) (four to six weeks after 5<sup>th</sup> dose, repeat a fourth blood test; if the result is "Non-Reactive/Negative" and get a 6th dose)
  - 6th Dose Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/ dd / yyyy) (four to six weeks after 6<sup>th</sup> dose, repeat a fifth blood test; if the final lab test result is "Non-immunity/Negative", student status will be "Non-Responder/Exception")
- Carrier (**Note:** No injections required and ATTACH copy of most recent "Antigen Positive" blood test and notify the medical officer)

**6. TWO CONSECUTIVE STEP-TUBERCULOSIS SKIN TEST (see instructions below)**

- First Timer-If you never had Two Consecutive Step-TB Skin Test done in a lifetime, it is mandatory that you complete and pay for Two Step-TB Skin Test.
- No Chest X-ray only-all students must provide proof of Two Consecutive Step-TB Skin Test and we will NOT accept a Chest X-ray report only.
- Failure to do Step 2 TB within 7-21 days after Step 1, you will need to REDO both TB Skin Test again and extra fees will apply.
- Negative (-) with less than (<10 mm)-If you have proof of previous Two Consecutive Step-TB Skin Test and the result was both "Negative", do annual Step 1-TB Skin.
- Positive (+) with more than (> 10 mm)-If you have proof of previous Two Consecutive Step-TB Skin Test and the result was "Positive", NO more annual skin test or Chest X-ray required and your doctor needs to do annual physical exam and answer letters (A-F) below.
- BCG vaccination-If you had BCG vaccination it is NOT a contraindication for skin test, you are still required to provide proof and complete a Two Step-TB skin test.
- It is mandatory that your doctor/health care professional properly complete, sign & stamp all the information outlined below. No exceptions!

**Previous: Step 1 TB Skin Test**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Date Given: mm / dd / yyyy)      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Date Read: 48-72 hours after date given)      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Induration size) (mm)

**Previous: Step 2 TB Skin Test (7-21 days after Step-1)**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Date Given on opposite arm: mm / dd / yyyy)      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Date Read: 48-72 hours after date given)      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Induration size) (mm)

**Current: Step 1 TB Skin Test**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Date Given: mm / dd / yyyy)      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Date Read: 48-72 hours after date given)      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Induration size) (mm)

**Current: Step 2 TB Skin Test (7-21 days after Step 1)**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Date Given on opposite arm: mm / dd / yyyy)      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Date Read: 48-72 hours after date given)      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Induration size) (mm)

**TB SKIN TEST POSITIVE WITH (MORE THAN >10 MM) INDURATION  
DOCTOR/PHYSICIAN MUST DO ANNUAL PHYSICAL EXAM & ANSWER LETTERS (A-F) BELOW:**

- a) Chest X-ray (ATTACH a copy of the X-ray report valid every four years) Result \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)
- b) History of disease? Yes or No Date (mm/dd/yyyy) \_\_\_\_\_
- c) Prior history of BCG vaccination (need documentation? Yes or No Date (mm/dd/yyyy) \_\_\_\_\_
- d) Does this student have signs/symptoms of active TB on physical examination? Yes or No
- e) INH Prophylaxis?(Treatment) Yes or No Date (mm/dd/yyyy) \_\_\_\_\_ Dosage \_\_\_\_\_
- f) Specialist (Public Health) Referred? Yes or No Date (mm/dd/yyyy) \_\_\_\_\_

Final Signature of doctor/physician/health care professional: \_\_\_\_\_ (pgs. 2-3)

Date (mm/dd/yyyy): \_\_\_\_\_ Medical Office Stamp: \_\_\_\_\_ (pgs. 2-3)



George Brown College & ParaMed Agreement Form  
(Complete prior to your ParaMed appointment)

Name  \_\_\_\_\_

Program  \_\_\_\_\_

I  \_\_\_\_\_ (Print Name) understand that any false statement is grounds for cancellation of admission.

I understand that the college has the right to cancel my admission privilege on the basis of medical information submitted or withheld. I understand that it is my responsibility to inform the appropriate George Brown College personnel of any communicable disease, special need, exception or medical condition which may place me at risk or pose a risk to others at George Brown College or on placement.

I will pay all the services fees and authorize ParaMed to review the above information.

\_\_\_\_\_  
(Student Signature) (Date)

**Element of Risk**

All experiential learning programs, such as field trips, clinical and field placements or job shadowing involve certain elements of risk. Injuries may occur while participating in this activity without any fault of the student, the placement or the college. By taking part in this activity, you are accepting the risk that you may be injured. Following the Health and Safety rules of your placement is required. By signing below you agree that you have reviewed the element of risk and are willing to comply with the Health and Safety Rules of your placement.

If an injury should occur, it must be reported immediately to your supervisor and to your faculty. Completing Workers Safety Insurance Board forms and reporting any injury while participating in placement must take place within **72 hours** of occurrence.

\_\_\_\_\_  
(Signature) (Date)

**Contact Us**

Suzette Martinuzzi, Coordinator at (416) 415-5000 ext. 3415 or via email [smartinu@georgebrown.ca](mailto:smartinu@georgebrown.ca)  
Clinical Pre-placement Office campus locations:  
(Mon-Wed) 51 Dockside Drive, Room 702, 7<sup>th</sup> Floor, Waterfront Campus  
(Thursday-Friday) 200 King Street East, Room 401B, 4<sup>th</sup> Floor, Building "A", St. James Campus  
Business Hours: 8:00 am to 3:30 pm, by appointment only or visit [FT Program Pre-placement](#)

**FREEDOM OF INFORMATION AND PROTECTION OF INDIVIDUAL PRIVACY ACT**

The personal information on this form is collected under the legal authority of the Colleges and Universities Act, R.S.O. 1980, Chapter 272, Section 5, R.R.O. 1990, Regulation 77 and the Public Hospital Act R.S.O. 1980 Chapter 410, R.S.O. 1986, Regulations 65 to 71 and in accordance with the requirements of the legal Agreement between the College and the agencies which provide clinical experience for students. The information is used to ensure the safety and wellbeing of students and clients in their care.