833 METRO DRIVE • LEBANON, PENNSYLVANIA, 17042 • TELEPHONE: 717-273-8551
FAX: (717) 279-7520 • www.lcctc.edu

May 2025

Dear Student and Parent/Guardian:

Welcome to the Lebanon County Career and Technology Center Dental Assistant Program!

To prepare you for your upcoming year we have put together some information for you concerning costs you will incur during the upcoming year.

The Dental Assistant Program at the Lebanon County Career and Technology Center is designed to give the student the theory and practical experience necessary to become a successful member of a professional oriented team. To accomplish this goal, it is necessary to have each student dress in a manner that is consistent with the profession. All students are required to wear a uniform as described in this letter.

We will be using Major League Screen Printing & Embroidery Inc. as our uniform supplier. Information is enclosed in this letter as to how to purchase your uniforms through Major League Screen Printing & Embroidery Inc. It is recommended that each student order three pairs of uniform pants and at least one warm-up jacket and at least 2 tunic tops. Also needed is a pair of sneakers, professional clinic shoes or a pair of uniform **crocs without holes for safety**. These may be purchased at any uniform/shoe store and the crocs may be any color, the crocs **should not have holes on top of the shoe.** It is recommended that you order your uniforms as soon as you get this letter to ensure on-time delivery**. Students must be in uniform for the first day of school.**

As you are probably aware, any health occupations field, in general, is considered to be a high-risk field. It is, therefore, highly recommended that the student has hepatitis immunizations. (You may have already had this immunization). If not, the series of injections will cost approximately $140. A tetanus update is also required, and both are normally covered by private family medical insurance or the medical card.

These injections should be started **before** school begins. As this immunization is highly recommended but not mandatory, we feel it is necessary to advise you that without it the

students will only be permitted to be passive viewers versus active participant when they go out on clinical rotations to private dental offices later in the year. This is for the protection of the students. In addition, each dental assisting student is required to have a dental exam prior to the beginning of school. If you have had an exam within the last four months just have the dentist fill it out and sign your dental form with the information requested. Please see the enclosed dental and medical forms that are to be filled out prior to the start of school and brought in on the first school day.

I would like to address transportation in this correspondence for you. During the second half of the year when we are in clinical rotations, **you will be responsible for your own way to and from the clinical sites.** This will be discussed further in the first week of school. Our goal is to assign you to a dental office close to your home or where public transportation is available.

We are highly recommending that this summer the student spends a minimum of two full days in a dental office of their choice. This being required in order that the student have a more realistic understanding of the knowledge, pace, and professionalism that will be required of them during the school year. **Please bring documentation (note) from a dental office that you have observed a dental assistant.** It will be collected on the first day of school**.**

Finally, please note that the Dental Assistant Program will begin Monday, August 26, 2024, for all students regardless of when your high school begins its 2024-2025 school year.

If you have any questions concerning this information contained herein, please feel free to call me at 717-273-8551 ext. 2168.

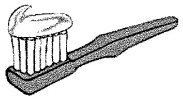
Have a great summer and we will see you in August!

Sincerely,

Nina K. Eckert

Nina K. Eckert, C.D.A
Dental Assistant Instructor

The Lebanon County Career and Technology Center



The below named individual has been accepted into the Dental Assistant Program

Your cooperation in performing a dental examination and completing this form will assist the student and the Dental Assistant Program

_____

Last Name First Name Middle Name

_____

Address

_____

Cell Phone Home Phone Work Phone

How often are teeth examined? _____

Care of Mouth? GOOD FAIR POOR

Care of Teeth? GOOD FAIR POOR

Periodontal Condition:

Gingiva _____ Bone _____

Mobility _____ Pockets _____

Recession _____ Color _____

Recommendations: _____

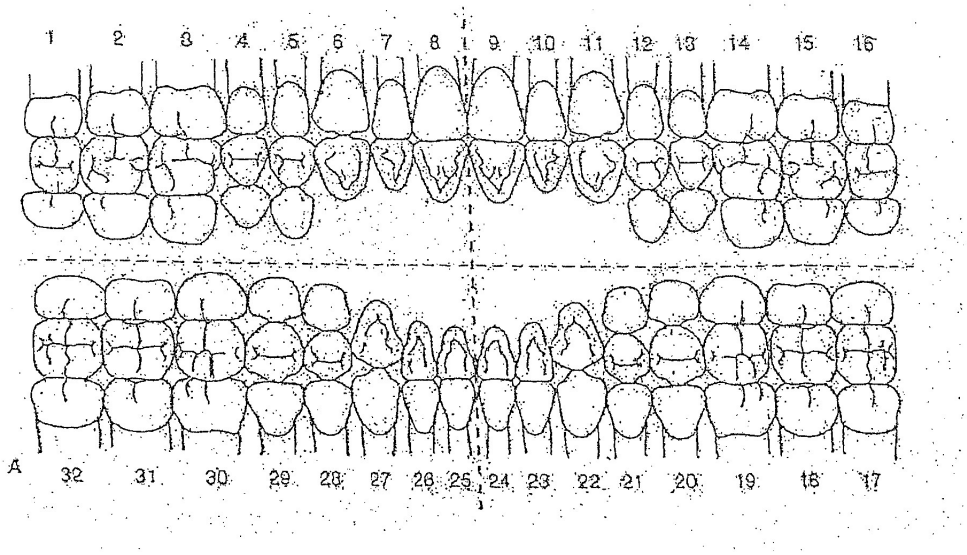
_____

_____

Dental Practice Name _____

Dental Practice Address _____

Dentist Signature _____Date _____



1. *PA State Police Criminal Record Check*

https://epatch.state.pa.us/Home.jsp

Click on Submit a "New Record Check (requires a credit card)"
Click "Accept" (for Terms and Conditions)
Fill out the required information (Reason for Request – choose: Employment)
Please note your: Control Number, your name as you entered it, and the date of request

After this is completed and processed
Click on "Check the Status of a Record Check"
Enter the required information, click Search, click on the Control Number, then Certificate Form, and print the Response for Criminal Record Check and provide us a copy

2. *PA Child Abuse History Clearance*

https://www.compass.state.pa.us/cwis/public/home

Click "Create Individual Account" (follow prompts)

After this is completed and processed, log into your account and click "To view the result, click here" and provide us a copy of your results

pennsylvania
DEPARTMENT OF HEALTH

Private or School

PARENT / GUARDIAN / STUDENT:

Complete page one of this form before

PHYSICAL EXAMINATION **student's exam. Take completed form to** Bureau of Community Health Systems **OF SCHOOL AGE STUDENT appointment.**
Division of School Health

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		

14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**CHECK ONE**			***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
	NORMAL	***ABNORMAL**	**DEFER**	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address_____ **Phone**_____

Signature of examiner_____ **MD ☐ DO ☐ PAC ☐ CRNP**

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

☐ Medical Date Issued:_____ Reason: _____

☐ Date Rescinded:_____ Medical Date Issued:_____ Reason:

☐ _____ Date Rescinded:_____

Medical Date Issued:_____ Reason: _____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER) STUDENT NAME:

The items below are required or optional (indicated in right-hand column) for enrollment in your CTC program. Please have all required items purchased and/or completed by the first day of school. If your program has a uniform requirement, you are expected to be in uniform the first day the CTC is in session. **Optional Information:** Do you have internet access or a computer in your home? Please be prepared to provide your home and/or cell phone number and email address at Parent Orientation.

If you have any questions, please contact me at 717-273-8551 ext. 2168 or by email at neckert@lcctc.edu.

Dental Assisting Program Checklist

Purchased or Completed	Item	Required/Optional (R or O)
☐	**2 uniform scrub tops**	**R**
☐	**1 warm-up jacket**	**R**
☐	**2 or 3 pairs of uniform pants**	**R**
☐	**1 pair of clean comfortable sneakers or crocs without holes on top of shoe**	**R**
☐	**Hepatitis injections are required/proof from your doctor**	**R**
☐	**Tetanus update (if needed) with proof from doctor**	**R**
☐	**Dental examination (form enclosed)**	**R**
☐	**We highly recommend that this summer the student spend a minimum of two full days in a dental office. Please bring documentation (note) from the dental office.**	**R**
☐	**Have the medical form filled out by your doctor (form enclosed)**	**R**
☐	**Transportation for clinical rotation in April and May required**	**R**

☐	**Pens, pencils, colored pencils, highlighters**	**O**
☐	**Folders and notebook paper**	**O**
☐	**Dividers for notebooks**	**O**
☐	**Clearances: Child Abuse Clearance and Criminal Background Check.** **https://www.compass.state.pa.us/cwis/public/home** **https://epatch.state.pa.us**	**R**