



## **Second Year Dental Hygiene Program**

(Dental Hygiene Year 2 - 2025)

The following list of questions may help you prepare for this fall:

<b>1. Will there be a clinic orientation?</b>
More information regarding clinic will be forthcoming.
<b>2. What are my clinical medical requirements?</b>
Please refer to the Placement Tab on the Dental Hygiene webpage for all Synergy placement information related to clinic. <a href="https://www.stclaircollege.ca/programs/dental-hygiene">https://www.stclaircollege.ca/programs/dental-hygiene</a>
<b>3. When will clinic begin and what are my clinic times?</b>
More information regarding clinic will be communicated via Blackboard.
<b>4. When will I receive my second-year clinical kit? How much will it cost? What does it include?</b>
The dental hygiene kit cost (approximately \$4,244.34) is included in your tuition. Your kit will be distributed during clinic orientation.
<b>5. What textbooks will we be using for year 2?</b>
Please contact the campus bookstore for textbooks required for year 2 of the dental hygiene program.



**DENTAL HYGIENE PROGRAM**  
**ONE STEP T.B. TEST REQUIREMENT FORM FOR**  
**ENTRANCE**  
**INTO YEAR 2 CLINIC**

I, \_\_\_\_\_ Birthdate: \_\_\_\_\_  
(Student Signature)

Health Card # \_\_\_\_\_, Authorize Dr./N.P. \_\_\_\_\_  
(Please Print)

TO RELEASE THE FOLLOWING INFORMATION TO ST. CLAIR COLLEGE.

NOTE TO PHYSICIAN/N.P.: It is recommended by the National Advisory Committee on immunization and the ONTARIO HOSPITALS ACT, REGULATIONS 518/88, that students in Health Care Programs meet the following health requirements in order to participate in the clinical component of the program.

If status is **unknown**: **a two-step** test is required.

Current T.B. skin test (+ve \_\_\_\_\_) (-ve \_\_\_\_\_) Date: \_\_\_\_\_

IF POSITIVE INDURATION IS >10 mm \_\_\_\_\_ >15mm \_\_\_\_\_ >25 mm \_\_\_\_\_

CHEST X-RAY: YES \_\_\_\_\_ NO \_\_\_\_\_

ANY INDICATION OF ACTIVE DISEASE: YES \_\_\_\_\_ NO \_\_\_\_\_

PROPHYLAXIS GIVEN: YES \_\_\_\_\_ NO \_\_\_\_\_

Physician/Nurse Practitioner Signature Section

Physician/Nurse Practitioner Signature \_\_\_\_\_ Date: \_\_\_\_\_

Physician/Nurse Practitioner Stamp (required)

**Comments of Physician/Nurse Practitioner:**