



## NORTHWOOD TECHNICAL COLLEGE DENTAL ASSISTANT PROGRAM PERMISSION FORM

**Student instructions:**

You need permission from your dentist to be a patient during clinical instruction in the Dental Assistant Program. Please have your dentist sign this permission form, then submit the signed form to one of your Dental Assistant Instructors when school begins.

If you do not have a dentist, you will need to schedule a dental appointment, **but do not have radiographs taken.**

Please notify Northwood Tech Health Services and the Program Director if there are any changes in your health status during your education in the Dental Assistant Program.

Students who are or may be pregnant will not be allowed to participate as a patient in Dental Radiography.

**I have read and understand that I will be a patient during clinical instruction.**  
**I agree to report changes in my health status to Northwood Tech Health Services & the DA Program Director.**

**STUDENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

For more information or if you have any questions, please contact:

- Jennifer Heutmacher-Holden, CDA, MS 715-788-7176 or [jennifer.holden@NorthwoodTech.edu](mailto:jennifer.holden@NorthwoodTech.edu)
- Northwood Tech health services

### DENTIST PERMISSION

**(Student's name)** \_\_\_\_\_ has been accepted into Northwood Technical College's Dental Assistant Program. During their course of study, they will be a patient in a clinical setting under the supervision of a Dental Assistant Program Instructor for the following procedures:

- |   |                                |
|---|--------------------------------|
| • Alginate Impressions / Bite Registrations | • Periodontal Dressing         |
| • Full Mouth series of Radiographs          | • Flossing                     |
| • Panoramic Radiograph                      | • HVE positioning and practice |
| • Coronal Polishing                         | • Tooth Whitening              |
| • Fluoride Treatment(s)                     |                                |

\_\_\_\_\_ **\*\*Student needs preventive antibiotics before being a patient.**

Thank you for giving permission that the above procedures may be performed on your patient.

**PRINT DENTIST NAME** \_\_\_\_\_

**DENTIST SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_