[insert logo]

*** THIS FORM MUST BE FILLED OUT COMPLETELY FOR YOUR CHILD TO PARTICIPATE***

With your **permission**, a public health nurse will provide your child with:

- A dental screening
- Fluoride varnish (prevents future cavities on the smooth surfaces of teeth)
- Oral Hygiene Instruction including nutritional counseling
- Report Card, including follow up information

This program does **NOT** take the place of regular check-ups at a dental office.

(Check One)

__**YES,** I want my child to have preventive dental services at school

__**NO,** I do not want my child to have preventive services at school (if NO, Fill out Child's Name only)

Parent/Legal Representative Name (Please Print) _____

Parent/Legal Representative Signature _____

Daytime Phone: _____ Best way to be reached? (Circle one)

Cell Phone: _____ Daytime phone Other_____(please provide number)

Relationship to child_____

Child's Legal Name: _____

Child's Address:_____ City:_____ County:_____ Zip Code:_____

Date of Birth: ____/____/_____ **Child's Social Security Number or ID Number _____-_____-_____**

School _____ **Teacher/Homeroom Teacher:** _____

What is your child's race: (Check all that apply)

__American Indian/Alaskan Native ___Pacific Islander

__Asian __White

__Black or African American

Ethnicity: __Hispanic or Latino

__Non-Hispanic or Latino

Does your child have Medicaid? (Circle one) YES or NO (Medicaid will be billed for preventive services)

Medicaid 10 Digit ID# _____ MCO # _____

Please mark which Managed Care Company you belong to with Medicaid:

_____Aetna Better Health of KY _____ WellCare _____ Passport _____Humana CareSource _____Anthem

Does your child have private Dental insurance? YES or NO

We do not accept private insurance but will be happy to see your child at our low fees based on a sliding scale

Number of persons in Household? _____ Yearly Household Income $ _____

***(This information is only needed to determine charges for Non-Medicaid students—Strictly Confidential**

Dental History:

Does your child have a dentist? (Circle one) YES or NO Dentist's Name _____

Is your child experiencing dental pain at this time? (Circle one) YES or NO

When was the last time your child went to the dentist? (Circle one)

In the past year More than one year ago Never

*******Please Turn Form Over—Signatures required on second page.**

Health History: Child's Medical Doctor _____ Phone #_____

Please circle if your child has ever had: Heart Murmur Latex Allergy Other allergy _____ _

Asthma Seizures/Epilepsy Diabetes Cancer/Chemotherapy Heart Problems (please explain) _____

Please list any other medical conditions (past or present) _____

Please list *all* current medications taken regularly _____

CONSENT FOR HEALTH SERVICES: (Expires 1 year from date signed)

Of my own free will I consent to care which may include, screening, assessments, preventive dental treatment, and any other health service given to me by staff or agents of this health department. I understand that no Guarantees are being made as to the effect of any assessments or treatment on me. I also understand I may be tested for (HIV) infection, Hepatitis B, or any other disease carried by blood or body fluids if a health care worker is exposed to my blood, body fluids or tissue.

This consent authorizes our providers to share pertinent information to ensure continuity of care. We may use medical information to provide, coordinate or manage your health care. We may consult with other health care providers, school administration, FRYSCs (Family Resource and Youth Service Centers) and/or MCO patient care coordinators concerning your or your child's need for care. Each party that is given personal health information is also bound by their signed agreements (HIPAA or FERPA) with their respective employers.

This program does not take the place of regular check-ups at a dental office. .

This form, when signed and filled in, contains Protected Health information and the information is to be protected according to the health Insurance Portability and Accountability ACT (HIPAA).

****My signature below acknowledges my receipt of the health department's "**NOTICE OF PRIVACY PRACTICES**" on the date stated.*

I understand that my child may be screened to check the retention of dental sealants by the public health dental hygienist during the following school year.

_____ _____

Signature of Parent/Guardian or other Authorized Person *Date*

Please sign and date this section if you have Medicaid

PAYMENT FOR SERVICE/ASSIGNMENT OF BENEFITS

☐ ASSIGNMENT OF BENEFITS: I request that payment of authorized medical insurance benefits be made to the [nsert health department name here] health department on my behalf, for services received. I also authorize the aforementioned health department to release medical information about me to Medicare, Insurance and other third party payors to determine payment for services.

I have read the above and have had an opportunity to ask questions. I understand the above statement as it applies to me and my child. My signature below indicates I do consent, authorize or declare as stated above.

_____ _____

Signature of Parent/Guardian or other Authorized Person *Date*

Please return to your child's classroom teacher or school nurse