

# School Dental Health Program

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## Dental Consent Form

Your child's school has been selected to participate in the Kansas School Dental Health Program. Dental Professionals will be offering services in your child's school such as sealants, fluoride varnish, and/or cleanings. These services are provided at no cost to you.

School Name \_\_\_\_\_ City \_\_\_\_\_

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender:  Male  Female

Race/ Ethnicity (check all that apply)	<input type="checkbox"/> White	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Other
	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Native Hawaiian/Pacific Islander	

Parent/Guardian Name \_\_\_\_\_ Daytime phone \_\_\_\_\_

Parent/Guardian Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

The State of Kansas and the Dental Professionals administering this program are dedicated to improving your child's dental health by offering outreach dental services. After your child is treated, you will receive a report stating what services were provided along with a dental referral if needed.

The information from my child's participation in this special event will be utilized anonymously for statistical purposes and information that identifies my child or family will never be disclosed in any form or publication.

**If offered, please check all services that your child may receive:**

<input type="checkbox"/> Sealants (if indicated)	<input type="checkbox"/> Fluoride Treatment	<input type="checkbox"/> Dental Cleaning
I give CHC/SEK permission to provide preventative dental services for my child and to collect payment from Medicaid, Health Wave or other dental insurance provider that covers my child's care. I understand that there is no out-of-pocket cost to me or to my child's school.		
<input type="checkbox"/> Medicaid # _____		
<input type="checkbox"/> Health Wave # _____		

Is your child covered under private dental insurance? (not Medicaid or Health Wave)  No  Yes

If yes, please provide insurance name and policy number \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



# School Dental Health Program

## Medical History



Student Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

When did your child last visit a dentist?     In the past year     More than a year     Never

Why did your child visit the dentist?

Cleaning/checkup     Toothache     Filling     Tooth pulled     Other

**Medical History: Check all that apply**

- |   |  |                                      |  |
|---|--|--------------------------------------|--|
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joints Pins/Screws | <input type="checkbox"/> Asthma      | <input type="checkbox"/> Congenital Heart Disorder |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Seizure disorder          |
| <input type="checkbox"/> Heart murmur           | <input type="checkbox"/> Autism                        | <input type="checkbox"/> Other _____ |  |

**Any Known Allergies:**     Latex     Amoxicillin/Penicillin     Other \_\_\_\_\_

Is your child required by physician to take pre-medication (antibiotics) prior to dental treatment?     No     Yes

- If yes, for what condition \_\_\_\_\_

Does your child have Special Health Care Needs ?     No     Yes

Surgeries/Hospitalizations/Other Medical Conditions: \_\_\_\_\_

Medications your child is currently taking? \_\_\_\_\_

Other information- Please tell us anything you think we should know about your child's health or previous dental experiences that would help us treat your child or meet their needs. \_\_\_\_\_

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

CHC/SEK will treat all patient information as protected health information (PHI) under HIPPA regulations, exchanging the PHI only with personnel employed by CHC/SEK and the facility/school who are responsible for medical treatment and/or record review.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

