HUDSON HEADWATERS HEALTH NETWORK

☐ **Yes, I give permission for my child to be enrolled in the school based dental program.**
Fill out the form in its entirety and return to your child's school.

☐ **No, I do not give permission for my child to be enrolled in the school based dental program.**
Fill in your child's name, school name, sign on reverse, and return to your child's school.

1. Demographic Information

Child's First and Last Name | Date of Birth | Sex

Race (check one):

__White __American Indian or Alaskan Native __Black or African American __Hispanic or Latino
__Asian or Native Hawaiian/other Pacific Islander __Multiracial __Other:

Name of School | Teacher | Grade

Child's Address | City, State, Zip

Parent Guardian Name (s) | Email Address

Home Phone | Cell Phone | Work Phone

2. Alternative Emergency Contact

Name | Relationship to Child

Home Phone | Cell Phone

3. Dental Coverage

___ My child has never seen a dentist.
___ My child does NOT have a regular dentist at this time. Do you need help finding a dentist for your child? ___Yes ___No
___ My child has been to a dentist for a cleaning within the last 6 months.
Date of last dental visit: _____ Date of next scheduled cleaning: _____

Dentist Name | Phone | Address

4. Dental Insurance Information

☐ **Uninsured (no dental coverage)**

☐ **Medicaid Insurance**

ID# | CIN# | SEQ#

☐ **Private Dental Insurance**

ID# | Group#

Plan Name | Employer | Insurance Phone #

Policy Holder Name | Social Security Number | DOB

PLEASE COMPLETE FRONT AND BACK OF FORM AND RETURN TO SCHOOL.

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5. Health Information

AIDS/HIV	Yes	No	Asthma	Yes	No	Birth Defects	Yes	No
Bleeding Disorders	Yes	No	Congenital Heart Disease	Yes	No	Diabetes	Yes	No
Fainting Spells	Yes	No	Epilepsy/Seizures	Yes	No	Rheumatic Fever	Yes	No
Heart Murmur	Yes	No	Hearing Loss	Yes	No	Kidney Disease	Yes	No
Heart Disease	Yes	No	GI Problems	Yes	No	Tuberculosis	Yes	No
Hepatitis/Liver Disease	Yes	No	Immune Deficiency	Yes	No	Vision Problems	Yes	No
Venereal Disease	Yes	No	High Blood Pressure	Yes	No	Low Blood Pressure	Yes	No
Psychiatric Disorders	Yes	No	Artificial Joints	Yes	No	Surgery	Yes	No
Hospitalization	Yes	No	Serious Injuries	Yes	No	Pregnancy	Yes	No

Comments:

Does your child take a fluoride supplement? (please circle)	Yes	No
Does your child take any medication on a DAILY basis? (please circle)	Yes	No

Please list daily medications: _____

Does Your Child have any allergies to the following items? (please circle)	Yes	No

Latex Tree Nuts Seasonal Resins Foods Antibiotics Penicillin Other: _____

6. Consent To Participate

- I consent to my child receiving the following dental services: assessments, cleanings, fluoride, and sealants.
- I understand that this consent may stay in effect for one (1) school year while my child attends this school; however this consent may be revoked by me or my designee at any time except to the extent that the person/ organization has already acted.
- It is the parent/guardian's responsibility to inform the dental provider and/or the school nurse of any changes in their child's medical information.
- I understand that a copy of my child's dental report may be given to the school nurse or designated site coordinator and that all information about my child will be kept confidential within the Partnering Agencies.
- If I have dental insurance, I authorize my insurance carrier to be billed for any services provided.
- I have been given a copy of the Hudson Headwaters Notice of Privacy Practices and Patient Bill of Rights.
- I understand that Hudson Headwaters Health Network may use my child's health information for treatment, payment, health care operations, and program evaluation.
- I understand that it is my responsibility to keep my child's dentist informed of services provided to my child by this program to avoid duplication of services which may result in me receiving a bill from my child's dentist.
- I have read and understand the dental program and I consent to have my child participate in the school based dental program.

_____ _____

Signature of Parent or Legal Guardian | Printed Name of Parent or Legal Guardian

_____ _____

Relationship to Child | Today's Date

PLEASE COMPLETE FRONT AND BACK OF FORM AND RETURN TO SCHOOL.