JUST KIDS DENTAL

2017-2018 Wisconsin School-Based Dental Program Consent

Dear Parent/Guardian:
Did you know an oral health program is available at your child's school? Just Kids Dental has partnered with your school district at no charge to provide oral health education and preventive dental services to underserved children at school. This program focuses on economically disadvantaged children enrolled in Forward Health and low-income children without dental insurance coverage per available limited grant funding. Just Kids Dental services are available to all children who wish to participate regardless of insurance status or ability to pay and does not single out specific children. Families covered under private insurance are encouraged to continue all care at your established family dentist. A parental consent form MUST be completed in INK and returned to school immediately before your child may receive services. Complete a SEPARATE form for EACH eligible child.

Services provided by a Registered Dental Hygienist include:
• Oral Health Instruction • Screening • Dental Cleaning • Fluoride Varnish • Sealants
• Toothbrush • Toothpaste • Floss

STOP STOP

IF YOU DECLINE SERVICES FOR YOUR CHILD
PLEASE DO NOT RETURN FORM AND STOP HERE

STOP STOP

School Name: _____ Teacher: _____

Child's LAST Name: _____ MIDDLE Initial: ____ FIRST Name: _____

Male: _____ Female: _____ Grade: _____ Child's Date of Birth: _____ Age: _____

Address: _____
Street City State Zip Code

Daytime Phone: _____ Emergency/Alternate Phone: _____

Ethnicity (select one): ___ Hispanic ___ Non-Hispanic ___ Other

Race (select one): ___White ___ AA/Black ___ Asian ___ American Indian/Alaska Native ___ Native Hawaiian/Pacific Islander ___ Unknown/Not Available

HEALTH HISTORY CIRCLE YES OR NO ALL QUESTIONS MUST BE ANSWERED FOR YOUR CHILD TO RECEIVE SERVICES

YES / NO Does your child have any allergies? List: _____
YES / NO Does your child take any medications? List: _____
YES / NO Has your child had any heart conditions? List: _____
YES / NO Does your child have any diseases or special health care needs? List: _____
YES / NO Does your child have private dental insurance?
YES / NO Has your child EVER seen a dentist?
YES / NO Has your child had a dental cleaning in the last 6 months? If yes, Name of Dentist and date of visit: _____
YES / NO Is your household eligible for • Free/Reduced Lunch • Energy Assistance • Daycare Assistance?
YES / NO Does your child have state public medical assistance/Forward Health? List 10 digit ID #: _____

COMPLETE ADDITIONAL QUESTIONS ON BACK OF FORM →

- I understand the nature of the treatment provided and authorize a Registered Dental Hygienist to provide preventive dental treatment advisable by the RDH.
- I authorize Just Kids Dental to discuss health and medical-related information with my child's current and/or previous dental offices.
- I acknowledge I am able to exercise my rights under HIPAA and privacy rules of the Health Insurance Portability Accountability Act of 1996 while being able to request additional information at any time by contacting Just Kids Dental at 218.206.4327, P.O. Box 146, Two Harbors, MN 55616.
- I understand permission is effective for a period of twelve months to provide follow-up services, including multiple fluoride varnish applications.
- I understand this program bills Medical Assistance insurance for eligible children. The treatment your child receives is not meant to be an alternative to regular dental care. Just Kids Dental strongly recommends that you seek out a dental home (family dentist) for routine dental care including any treatment which may be advised.
- I consent to allow pictures of my child to be taken and possibly used in newspapers, web or for promotional use of Just Kids Dental (child's name will never be used).
- Please print NO if you do not consent to photo portion of form: _____ .

By signing below, as parent/legal guardian of above named child, I consent for my child to participate in the JUST KIDS DENTAL SCHOOL-BASED DENTAL PROGRAM for the 2017/2018 school year. I understand that if I fail to sign this dental consent form, my child will not receive any services through Just Kids Dental.

Print Name of Parent/Guardian **Signature** **Relationship to Child** **Today's Date**

COMPLETE INFORMATION REQUIRED FOR WISCONSIN SEAL-A-SMILE PROGRAM FUNDING

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CHILD: (CIRLCE ONE)

A. Does your child use medicine prescribed by a doctor? YES / NO **IF YES, WHAT KIND?**_____

B. Does your child need or use more medical care than other children the same age? YES / NO

C. Does your child have trouble doing things most children the same age do? YES / NO

D. Does your child need or receive special therapy, such as physical, occupational or speech? YES / NO

E. Does your child need counseling or treatment for behavior problems, emotional problems, or delays in walking, talking or activities other children the same age can do? YES / NO

If you selected "yes" to any of the questions (A-E) above: Has this lasted or is expected to last at least 12 months? YES / NO