

SCHOOL - DENTAL OUTREACH PROGRAM

2021-2022 Consent Form



Your child's school has been selected to participate in the Kansas School Sealant Program. Dental Professionals will be offering services in your child's school such as sealants, fluoride varnish, SDF and/or cleanings. **There will be no cost to you or the school for these services.** **PrairieStar will bill all insurance for services.** If your child has private dental insurance (ex: Delta) it is **NOT** necessary to participate in this program but that is up to parent/guardian.

HIPAA Privacy Practice & Non-discrimination policies can be located on School or PrairieStar Website.

School or Program Name: _____ Student Grade _____ Teacher: _____

Child's Legal Name: _____ Date of Birth _____ ☐ 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/Pacific Islander |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Native Hawaiian | |

Parent/Guardian Name: _____

Address: _____ City / Zip _____

Phone _____ Alt. Phone _____

Health History

Does your child have a dentist? ☐ Yes ☐ No Name of Dentist: _____

When did your child last visit the dentist? ☐ Less than 6 months ☐ 6 months ☐ year ☐ more than a year ☐ never

- | | |
|--|--|
| <input type="checkbox"/> Recent Dental Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Asthma or Wheezing | <input type="checkbox"/> Fainting/Seizures /Epilepsy |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Liver Problems /Hepatitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach Troubles / Ulcers |
| <input type="checkbox"/> Hemophilia/ Bleeding Problems | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Silver Allergy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Problems (Describe) _____ | <input type="checkbox"/> ANTIBIOTIC NEEDED PRIOR TO TREATMENT |

List allergies (including medication)

Other conditions not listed

Name of physician and pharmacy

List Medications child is taking: _____

The state of Kansas and the Dental Professionals administering this program are dedicated to improving your child's oral health by offering outreach dental services. Services may include treatment provided 2X during school year. After your child is treated you will receive a report stating what services were provided along with a dental referral if needed.

Data obtained from your services may be utilized anonymously for statistical purposes for the National Institute of Health. information that identifies you will never be disclosed in any form or publication. However, you are granting permission and consenting to a photograph for publicity purposes, which may include print, television, or web. Consent is given voluntarily without compensation.

Our services include: Cleaning, Sealants and Fluoride Treatment.

- ☐ I consent and authorize PrairieStar Dental Outreach to use Silver Diamine Fluoride/SDF as needed to slow down the tooth decay process. Additional consent is required.

I give PrairieStar Health Center permission to provide preventative dental services for my child and to collect payment from Medicaid and private insurance.

☐ Name of Insurance Co. _____

Group ID # or Social Security # _____

☐ Policy Holder Name _____ Policy Holder Date of Birth _____

Parent/Guardian Signature _____ Date _____