



HANCOCK COUNTY SCHOOLS

P.O. Box 1300, New Cumberland, WV 26047 (phone) 304-564-3411 (fax) 304-564-3990 <http://boe.hancock.k12.wv.us>

Student Oral Health Form

Patient Information

Child's Name (Last, First, MI) _____ Date of Birth (MM/DD/YYYY) _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Guardian _____ Phone _____

Oral Health Service

Please provide date of service in applicable box below:

Date of service

School Entry	2nd Grade	7th Grade	12th Grade
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Current Oral Health Services:

Type of Services Provided? ☐ Examination

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions?

☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Additional Information

Oral Health Provider's Contact Information and Signature

Provider Name (please print) _____ Phone Number _____ Fax Number _____

Practice Name _____ Address _____

Provider Signature _____ Office Contact email _____

FERPA/HIPAA CONSENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN DENTAL/ MEDICAL PROVIDERS and SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____
Last First MI DOB

I, the undersigned, do hereby authorize (name of agency, dental and/or health care providers):

(1) _____ (2) _____
to provide health information from the above-named child's dental and/or medical record to and from:

School District to Which Disclosure is Made

Address / City and State / Zip Code

Contact Person at School District

Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

Requested information shall be limited to the following:

All minimum necessary health information; or Disease-specific information as described:

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/ persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

Printed Name

Signature

Date

Relationship to Patient/Student

Area Code and Telephone Number

