COMMUNITY UNIT SCHOOL DISTRICT NO. 20

1802 Cedar Street

Lawrenceville, IL 62439

Name: _____

Date: _____

This letter is to notify you that all students in **Illinois** in **kindergarten, second, sixth and ninth grades** are required to have an oral health (dental) examination performed by a licensed dentist. The dentist is to complete and sign the attached **"Dental Examination Form"** as proof of the examination. This form is required to be returned to school prior to the **deadline of *May 15, 2020.***

If this student had a **dental examination anytime after Nov. 15, 2018**, the examining dentist may complete this form based on that examination.

Attached is an application for "Dental Safari" a mobile dentist which will be at **Parkview on December 13th, 2019 and LHS on December 10, 2019**. If you prefer to use this service, which would cover the above requirement, please complete and return the application by **Dec. 2, 2019**. If payment is required do NOT send at this time. This rule also allows a **waiver** for children **who show undue burden or lack of access to a dentist**. The **Waiver form** is on the back of the attached "**Dental Examination Form.**" If this would apply to this student, please complete and sign the Waiver form and return it to school by May 15th.

If you have a **religious objection** to a dental examination, you must provide a **signed detailed statement of the objection** by the same deadline.

One of the following forms must be provided:

1) Completed Examination Form
2) Dental Safari Application
3) Waiver
4) Religious Objection - Please Contact Nurse For More Information

If one of the 4 options is not met by the deadline this may lead to the school holding the student's report card. If you have any questions or problems, please call the School Nurse's office at 943-6161.

Sincerely yours,

Erica Steffey, R.N.

CUSD #20 School Nurse

Dentists that take Illinois All Kids

Kool Smiles	Kool Smiles	Ryan Kapp, DDS	Effingham Health Center	Dental Office
1-812-466-6527	1-88-920-2072	1-812-753-1039	1-217-342-0211	618-783-3714
Terre Haute, IN	Evansville, IN	Fort Branch, IN	Effingham, IL	Newton, IL

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle		Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code		Telephone:
Name of School:	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

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State of Illinois
Illinois Department of Public Health

DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name: Last	First	Middle		Birth Date: (Month/Day/Year)
Address: Street	City			ZIP Code
Name of School:	ZIP Code		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian: Last Name	First Name			
Student's Race/Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown ☐ Other_____				

I am unable to obtain the required dental examination because:

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid / All Kids).

☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid / All Kids.

☐ My child is enrolled Medicaid / All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid / All Kids.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Parent or Guardian Signature _____ Date:_____

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217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

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DENTAL CONSENT FORM

Dental Safari Company
7562 Old Rt 13
Marion, IL 62959
(618) 993-8333
(618) 993-8335 fax
contact@DentalSafariCompany.com

we're on facebook

School _____ Grade _____

County _____ Teacher _____

Now! Can Fill Out / Submit Online!!

Parents/Guardian

DENTAL SAFARI COMPANY, a fully licensed, professional corporation, will be at your child's school. By signing this consent form, your child will receive a visual exam (no x-rays) by a licensed dentist, a cleaning, Fluoride, and sealants as needed.

ALL CHILDREN ARE ELIGIBLE. Please select the method of payment you would like to use (check one):

- ☐ Medicaid / All Kids (9-digit ID# required)
- ☐ Grant Fund – Child is on the free or reduced lunch program but has NO MEDICAL CARD #.
- ☐ Private Insurance – Most private insurance pays 100% on services we perform (questions: call (618) 993-8333)
- ☐ Cash (or Check) Payment (pick one) ☐ **Full Price** $128 [due with consent form]
- ☐ Credit Card / PayPal (go to website) ☐ **Reduced Fee** ($75 total. [due with consent form] ***Must Sign Declaration below)***

www.DentalSafariCompany.com

Cash Payment Declaration/Reduced Fee Waiver

For financial reasons, Parent/Guardian is unable to pay Full Price for dental services at this time.

_____

(print name) *signature* *date*

Child's (legal) Name _____ ☐ Male ☐ Female Birth Date ____ / ____ / _____

Address _____ City _____ ZIP _____ Phone _____

Cell Phone: _____ **OK, to text?** ☐ Yes ☐ No **e-mail:** _____

Is Child Eligible for Free or Reduced Lunch? ☐ YES ☐ NO *(9-digit # on back of Card)*

Medical Card KidCare / All Kids Card RECIPIENT ID# ___ ___ ___ ___ ___ ___ ___ ___ ___

Does Your Child have PRIVATE Dental Insurance? ☐ YES ☐ NO

Primary Card Holder Name _____ Phone _____ Employer _____

Primary's Address _____

Primary's: Birth Date ____ / ____ / _____; Primary's Soc. Sec. #: _____ - _____ - _____

DENTAL insurance company _____ Insurance Company Phone _____

Member ID#: _____; Group #: _____

☐ **YES** ☐ **NO** **NEED FOR PREMEDICATION?** – Does child need premedication **with antibiotics** for dental treatment?
** **IF YES** – Please call our office: (618) 993-8333

HEALTH HISTORY – PLEASE FILL OUT COMPLETELY

Has your child had any history of the following? Check ALL that apply:

☐ AD/HD	☐ Blood Disorders	☐ Diabetes	☐ Heart	☐ Speech Difficulties
☐ Allergies (seasonal)	☐ Cancer	☐ Ear Aches	☐ Heart Murmur	☐ Surgeries
☐ Asthma	☐ Cerebral Palsy	☐ Growth Problems	☐ Pregnancy	☐ Tobacco / Drug Use
☐ Autism	☐ Chronic Sinusitis	☐ Hearing	☐ Seizures	☐ Other

Other (checked above) Please Describe: _____

☐ **YES** ☐ **NO** **Is child allergic to ANY medication?** list _____

☐ YES ☐ NO Is child taking ANY medications at this time?

_____

☐ YES ☐ NO Has your child ever suffered injuries to the mouth, head, or teeth?

_____

☐ YES ☐ NO Does child's home have well water?

6-Month Recall?

If we return in six months, would you like your child to receive a dental exam, cleaning, Fluoride and sealants at that time as well?

☐ YES ☐ NO

☐ **Undecided,** would like more information

** The American Academy of Pediatric Dentistry (AAPD) recommends children visit the dentist at least every six months (twice a year)*

IMPORTANT: PARENT / GUARDIAN SIGNATURE REQUIRED

I am a custodial parent or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment described, and allow the school nurse/school representative and dental provider access to child's dental record.

_____

SIGNATURE *(RELATION TO CHILD)* *DATE*

* By signing, you give permission to treat your child and understand your HIPPA rights.
[HIPPA form can be reviewed at www.DentalSafariCompany.com, or a copy can be sent to you by using DENTAL SAFARI COMPANY'S contact information in upper-right corner of this Consent Form]
* Also, gives permission for HFS, QA Audits and providers to return to your school and re-check your child's sealants.

Optional: Photo/Video Release For Minor Child

_____ parent/guardian

_____ child

I, as parent/guardian, of the above child, give permission to Dental Safari Company to take and use pictures/videos in promotional material with no compensation to me. NOTE: Your child's name will not be used unless further permission is given.

_____

(signature)

Dentist's Initials _____