SCHOOL - DENTAL OUTREACH PROGRAM
2019-2020 Consent Form

PrairieStar Health Center

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, and/or cleanings. **There will be no cost to you or the school for these services.** **PrairieStar will bill Medicaid for services.** If your child has private dental insurance (ex: Delta) it is **NOT** necessary to participate in this program.

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

❒ White ❒ Asian ❒ American Indian/Alaska Native ❒ Other/Pacific Islander

❒ Black/African American ❒ Hispanic ❒ 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? ❒ 6 months ❒ year ❒ more than a year ❒ never

❒ Recent Dental Problems
❒ Asthma or Wheezing
❒ Behavioral Problems
❒ Tuberculosis
❒ Rheumatic Fever
❒ Diabetes
❒ Hemophilia/ Bleeding Problems
❒ Heart Problems (Describe)
❒ Silver Allergy

_____

_____

❒ Sickle Cell
❒ Fainting/Seizures /Epilepsy
❒ Liver Problems /Hepatitis
❒ Kidney Problems
❒ HIV/AIDS
❒ Cancer
❒ **ANTIBIOTIC NEEDED PRIOR TO TREATMENT**

List allergies (including medication)

_____

_____

Other Medical 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 be 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.

The individual's participation in this special event may be utilized anonymously for statistical purposes for the National Institute of Health and Information that identifies you will never be disclosed in any form or publication. You are consenting to a photograph for publicity purposes, which may include print television or web. Consent given voluntarily and 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 information is available upon request.

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

❒ Medicaid # _____

Do you have private dental insurance (not Medicaid) ❒ yes ❒ no

❒ Eligible for Free/reduced lunch program

Parent/Guardian Signature _____ Date _____