Mission Valley Elementary **U.S.D. 330**

12913 Mission Valley Rd., Ste. B • Eskridge, Kansas 66423 • (866) 557-6686 • Fax (785) 409-6219

February 20, 2020

Dear Parent/Guardian,

The attached dental consent form is for students who wish to receive **cleaning, fluoride treatments or sealants**, provided by Healthy Smiles, a portable preventive dental program. This is a program in **addition** to any screenings previously done at school offered by Healthy Smiles and the Community Health Ministry in Wamego, KS.

If you would like for your student(s) to receive any of the above mentioned services, please fill out the consent form, *front and back*, and return to school by Thursday, March 5, 2020. This program is designed to provide dental services to children that are NOT receiving services elsewhere. Healthy Smiles will be here March 23, 2020 to perform these services. Please note that some services do require payment. If a student has Medicaid, KanCare, or receives free/reduced meals no payment is required. Students not qualifying will need to pay the reduced rate of $30 for dental cleaning and fluoride treatment. **Sealants are free to all students this year.** To assure confidentiality, please return in a sealed envelope to the office.

Please call if you have any questions or concerns.

Rita S RN

Rita Swenson, RN

Consent for Dental Hygiene Services

Healthy Smiles Community Dental Hygiene Program

Community CARE MINISTRIES

Community Care Ministries is providing dental hygiene services at your child's school this year. **ALL** children are invited to participate in the program.

If applicable, I consent to have my dental insurance billed and Community Care Ministries, Inc. receive all reimbursement. If uninsured I understand that SEALANTS are FREE and I am responsible for a $30 copay for all other services, due on the date of service.

Student Name: _____ Date of Birth: ____/____/____

School _____ Grade _____ male / female

Parent/Legal Guardian Name: _____ Phone _____

Address: _____ City _____ State _____ County _____ Zip _____

Dental Insurance Name: _____ ID# _____

** KanCare / Delta Dental / BCBS only ** Subscriber's DOB: _____

e-mail: _____ Do you have a Dental Home [ ] yes [ ] no

Please check the appropriate box by each service you wish your child to receive, as needed. Your consent will cover the fall and spring visits to your school.

YES	NO		
☐	☐	**Dental Assessment** -	Check for obvious signs of decay or other concerns by a hygienist.
☐	☐	**Dental Cleaning** -	Removal of dental plaque and debris to prevent cavities, gingivitis & periodontitis.
☐	☐	**Fluoride Varnish** -	A topical placed to make teeth more resistant to acid attacks, reverse early decay and strengthen teeth to prevent future decay.
☐	☐	**Dental Sealants** -	A barrier applied to permanent teeth to prevent cavities.
☐	☐	**Dental X-rays** -	Digital images taken **as needed** to identify potential areas of concern.
☐	☐	**Extended Services** -	As necessary, Parent/Guardian contact will be attempted prior to service with full explanation of procedure.

I hereby give permission for any dental treatment selected above that is deemed necessary. I understand that the assessment, dental cleaning, fluoride, sealants, x-rays and extended services will be performed by a dental hygienist. I understand the treatment provided does **not** constitute an examination by a dentist and it is recommended my child see a dentist for a yearly examination and/or further dental care. A copy of treatment will stay at the school where treatment was provided. The CCM Dental Program will treat all patient information as protected health information (PHI) under HIPPA regulations, exchanging the PHI only with personnel employed by CCM and appropriate facility staff who are responsible for medical treatment, record review, and billing. CCM does report personal and household information into the MAACLink computer system. Non identifiable vital statistics such as oral condition, age, number of teeth, etc may be gathered for research purposes only.

Parent/Guardian Signature _____ **Date** _____

Race/Ethnicity: (check all that apply) How many people in your household _____

☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American

☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ Other

After your child is treated, you will receive a report card of the results and a referral to a dentist if needed.

Working

Healthy Smiles
Medical History Form

Student Name _____ Date of Birth: ___/___/___

School _____ Grade _____

When did your child last visit a dentist? □In the past year □ More than a year □ Never

Why did your child visit the dentist?
□Checkup □Cleaning □Mouth Pain □Filling □Tooth pulled □*Other*

Medical History: Check all that apply
□Heart murmur □Autism □Asthma □Diabetes □Hepatitis □Heart Disease
□*Artificial Joints Pins/Screws* □ Artificial Heart Valve □Congenital Heart Disorder
□Seizure disorder □Other _____

Any Known Allergies:
□Latex □Amoxicillin/Penicillin □Other _____

Is your child required by physician to take pre-medication (antibiotics) prior to dental treatment? □No □Yes
If yes, for what condition _____

Does your child have special health care needs? □No □Yes
If yes, please explain: _____

_____

Surgeries/Hospitalizations/Other Medical Conditions:

_____

Medications your child is currently taking?

_____

Other information- Please tell us anything you think we should know about your child's health or previous dental experiences that would help us treat your child or meet their needs.

_____

_____

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

Parent/Guardian Signature _____ **Date** _____