



Altoona-Midway USD 387
Superintendent: Mr. Brent Kaempfe
20584 US 75 Hwy
Buffalo, KS 66717
620-537-7721 Fax# 620-302-2080

Altoona-Midway Elementary School
Principal: Kim Reazin
833 River St., P. O. Box 128
Altoona, KS 66710
620-568-5725 Fax # 620-568-5755



Altoona-Midway High School
Altoona-Midway Middle School
Principal: Darrin Ashmore
Activities Director: Jeff Almond
20704 US 75 HWY
Buffalo, KS 66717
620-537-7711 Fax # 620-537-2641

Date 7-28-2020

Dear Parent/Guardian,

Community Health Center of Southeast Kansas will be providing **dental screenings** and **dental services** to USD 387 students during the 1st semester of the 2020/2021 school year.

Dental Screenings

To comply with Kansas State Statute 72-5201, school children (K-12) should receive annual school-based dental screenings. All Students will be screened unless you notify me by phone, note, etc. to let me know to take your child off the list. Screenings are **free** and they will take a quick look in the mouth to determine if the child has an urgent dental need. A take home note will go home with all children who are screened to inform parents if this child needs to see their dentist.

Dental Services

Parents who wish for their children to have services will need to sign and return the consent form. Parents who do not want their children to have services may opt out by not returning their consent form. These services include:

- **Preventive services:** Cleaning, Sealants, Fluoride Treatment, Silver Diamine Fluoride Treatment, Temporary Fillings
- **Other services if available:** Exam, X-Rays, Local Anesthesia, Restorative Care (Fillings), Primary Tooth Extractions, Pulp Therapy, Stainless Steel Crowns, Space Maintainers and Administering Tylenol or Ibuprofen as needed. Insurance will be billed, if available, but please note that there is no out-of-pocket cost to the school or the family for these services.

If you want your child to have dental services the consent form must be returned to school by August 30th. Otherwise your child will receive a free screening only.

Please feel free to call the school office with any questions you may have. **If you DO NOT wish for your child to receive the free dental screening or dental services please provide proof of their most recent dental appt (within the last year) or upcoming appointment.**

Sincerely,

Kara Kariker, RN
USD 387
School Nurse

For Office Use Only

Screening #s =

P / F / S=

SDF=

Urgent=

EO: 3 ___ 14 ___ 19 ___ 30 ___



Dental Consent Form

Community Health Center of Southeast Kansas will be providing dental treatment at your child’s school this year. All children are invited to participate in the program, but the program has a special focus on those children not receiving services elsewhere. No child will be denied services based on insurance status or ability to pay. However, insurance (if available) will be billed.

School Name _____

Student Name _____ **DOB:** _____ **Grade:** _____ **Gender:** _____ **Age:** _____

Parent Guardian Name _____ **Daytime Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Student’s Race:

- American Indian or Alaskan Native
- White
- Native Hawaiian or Other Pacific Islander
- Asian
- Black or African American
- Other Race

Student’s Ethnicity (circle one) Hispanic or Latino OR Not Hispanic or Latino

DENTAL INSURANCE

Please complete the insurance section below. We will bill your insurance for services provided.

- KanCare (Aetna, United Health Care, Sunflower) # _____
- Medicaid (Oklahoma or Missouri)# _____
- No Insurance
- Commercial/ Private Insurance

Commercial Insurance Policy Holder Name _____ **DOB** _____ **SSN#** _____
Insurance Company _____ **Policy#** _____ **Group#** _____

As parent or legal guardian of the patient named above, I give Community Health Center of Southeast Kansas permission to provide my child with dental services by CHC/SEK clinical professionals as is necessary in their judgement. I understand that no promise, guarantee, or warranty has been made regarding the result of any care provided by CHC/SEK. This dental treatment can include the following: **Cleaning, Sealants, Fluoride Treatment, Silver Diamine Fluoride Treatment, Temporary Fillings, Exam, X-Rays, Local Anesthesia, Restorative Care (Fillings), Primary Tooth Extractions, Pulp Therapy, Stainless Steel Crowns, Space Maintainers and Administering Tylenol or Ibuprofen as needed.** This consent is valid for one year from the Parent/Guardian Signature date below.

Please list any services below you do **NOT** want your child to receive:

Parent/Guardian Signature _____ **Date** _____



Please complete and sign the Medical History Form on the other side

Medical History Form

Student Name _____ DOB _____

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
- Pain
- Other
- Cleaning
- Filling
- Tooth pulled

Medical History: Please check all that apply

- Heart Murmur
- Asthma
- Heart Disease
- Artificial Joints/
Pins/Screws
- Artificial Heart Valve
- Congenital Heart
Disorder
- Seizure Disorder
- Diabetes
- Hepatitis
- Other

Allergies:

- Latex
- Amoxicillin/
Penicillin
- Other

Please list drug allergies: _____

Who does the patient use for his/her medical care? _____

Is your child required by a physician to take a pre-medication (antibiotics) prior to dental treatment?

If yes, what condition _____

Does your child have special health care needs? If yes, please explain: _____

Surgeries/ Hospitalizations / Other Medical Conditions: _____

Please list all medications your child is currently taking: _____

Please tell us anything you think we should know about your child's health of 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 _____



Community Health Center of Southeast Kansas/ 924 N Broadway/ Pittsburg, KS 66762/ 620-231-6788/ www.chcsek.org