School Dental Health Program (CONSENT FORM)
School: Humboldt USD258 (√ One) Elementary ___ Middle School___ High School Grade: ____ Teacher: _____________________________________

Your child's school has been selected to participate in the Kansas School Dental Health Program. Dental Professionals will be offering services in your child's school such as sealants, fluoride varnish, and/or cleanings. While any child is eligible to participate, these services are intended for those children without a regular or family dentist and who would not otherwise receive this care due to limited family income or lack of insurance coverage.

Student Name______________________________ Date of Birth___________ Age_____ Gender: □ Male □ Female

Race/ Ethnicity	**(check all that apply)**	□ White
□ Black/African American	□ Asian	□ Hispanic
□ American Indian/Alaska Native	□ Native Hawaiian/Pacific Islander	□ Other

Parent/Guardian Name_____________________________________ Daytime phone_____________________________

Parent/Guardian Address__________________________________ City_______________ State____ Zip_____________

The State of Kansas and the Dental Professionals administering this program are dedicated to improving your child's dental health by offering outreach dental services. After your child is treated, you will receive a report stating what services were provided along with a dental referral if needed. The information from my child's participation in this special event will be utilized anonymously for statistical purposes and information that identifies my child or family will never be disclosed in any form or publication.

If offered, please check all services that your child may receive: (PLEASE CHECK OFF ALL DESIRED)

□ **Sealants (if indicated)**	□ **Fluoride Treatment**	□ **Dental Cleaning**

I give CHC/SEK permission to provide preventative dental services for my child and to collect payment from Medicaid, Health Wave or other dental insurance provider that covers my child's care. I understand that there is no out-of-pocket cost to me or to my child's school.

□ Medicaid	**#:**	
□ Health Wave	**#:**	
□ Private Health Ins.	**Name:**	**#:**

Parent or Guardian Signature:	Date:

When did your child last visit a dentist? □In the past year □ More than a year □ Never
Why did your child visit the dentist? □Cleaning/checkup □Toothache □ Filling □Tooth pulled □Other

MEDICAL HISTORY	□Artificial Joints Pins/Screws	□Asthma	□Congenital Heart Disorder
□Diabetes	□Heart Disease	□Hepatitis	□Seizure disorder
□Heart murmur	□Autism	□ Artificial Heart Valve	□ 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

Medications your child is currently taking? ____

Does your child have Special Health Care Needs? If yes, for what condition: ___________________________________

Surgeries/Hospitalizations/Other Medical Conditions: ____

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.
CHC/SEK will treat all patient information as protected health information (PHI) under HIPPA regulations, exchanging the PHI only with personnel employed by CHC/SEK and the facility/school who are responsible for medical treatment and/or record review.

Parent or Guardian Signature:	Date: