FORM FOR PreK- Grade 2
Call 434-2327 or learn more at:
www.ChildrensDentalNetwork.org

CHILDREN'S Dental NETWORK
Working Together for Healthier Kids

ALEXANDER EASTMAN FOUNDATION

Dear Parent/Guardian,

The 2018-19 Children's Dental Network (CDN) is a program operated by Greater Derry Oral Health Collaborative Corporation (GDOHCC), a 501 (c)(3) non-profit organization independent of the schools in which its programs are delivered. **ALL children are encouraged to participate in screenings.** A volunteer dentist or CDN hygienist will screen participating students' teeth and written results will be sent home.

ALL PARENTS for gr. PreK-2: *please* respond and return this form promptly.

Student's Name _____ ☐**M** ☐**F** **Teacher** _____ **School** _____

☐ **NO,** I do not want my child to participate. Signature. _____
Do not continue. Please return form. Thank you.

☐ **YES**, I want my student screened. All PreK-2nd grade students are welcome.

Parent/Guardian_____ Day Phone_____ Grade _____

Does your child have a dentist? _____ Date of last dental visit? _____ Next visit? _____

Signature _____ Date _____

If your child receives routine dental care, do not continue. *Return form. Thank you.*

If your student is not able to have preventive care in a dental office, complete the screening permission above and this section and sign on reverse. Treatments include cleanings, topical fluoride varnish, decay-stopping fluoride, dental sealants, and temporary fillings. There is no drilling. Sealants are coatings that protect the chewing surfaces of teeth. Decay-stopping fluoride treatments, for back teeth only, help stop a cavity from getting bigger and make it feel better. (also called SDF- silver diamine fluoride) You can tell it worked if cavity becomes hard and black over time. This permission is for fall and spring visits.

Cell Phone _____ E-Mail _____ What is best way to reach you? _____

Child's Date of Birth ____/_____/____ Address:_____

1. **Does your child have a congenital heart defect requiring pre-medication with antibiotics before dental treatment?** ☐ Yes ☐ No
2. **Does your child have any allergies?** ☐ Yes ☐ No If yes, explain. _____
3. **Has your child ever had any serious health problems?** ☐ Yes ☐ No Explain: _____
4. **Why is student unable to receive dental treatment in a dental office? Check all that apply**.
   ☐ Can't find a dentist who accepts child's insurance ☐ Cost ☐ Transportation ☐ Fear
   ☐ Can't afford our insurance co-pays ☐ Can't take time off from work ☐ Other _____
5. **Does your student have medical insurance?** ☐ Yes ☐ No **Dental insurance?** ☐ Yes ☐ No If so, which kind of dental ins.?
   ☐ Name of private insurance: _____
   ☐ NH Medicaid – If yes, clearly **write name and Medicaid ID number as they appear on the card:**
   Child's Name _____ **Medicaid** ID number ☐☐☐☐☐☐☐☐☐☐☐

TURN OVER- signature required

If your child has NH Medicaid, there is no charge for treatment and **CDN will bill Medicaid**. **Please use the table below to determine your suggested contribution if your child is not covered by Medicaid.** Please make checks payable to: *GDOHCC.* No child will be denied service if unable to afford fees. ☐ **A check is enclosed for $ _____**
Thank you!!

	Monthly income equal to or less than	Cost		Monthly income between	Cost		Monthly income equal to or greater than	Cost
2	$2,743	Free		$2,744 – 4,114	$10		$4,115	$20
3	$3,463	Free		$3,464 – 5,194	$10		$5,195	$20
4	$4,183	Free		$4,184 – 6,274	$10		$6,275	$20
5	$4,903	Free		$4,904 – 7,354	$10		$7,355	$20

Read the attached Notice of Privacy Practices and Sign Consent Below

- **I hereby give permission** for the Children's Dental Network **to treat my child twice this school year**, with screening, cleaning, topical fluoride varnish, dental sealants, decay-stopping fluoride and temporary fillings as needed. *Not all types of cavities can be treated at school.
- **I understand that the services provided at school cannot replace regular examination and treatment in a dental office.** I understand that a registered dental hygienist (or senior dental hygiene student from NHTI or senior dental student from UNE, under direct supervision by Children's Dental Network) will provide the services.
- **I understand that** a photograph may be taken of my child's tooth or teeth if my child cannot be identified from the picture.
- **I have read the *Notice of Privacy Practices* and I further understand** that Children's Dental Network may share my child's dental assessment for treatment and payment activities with the school nurse, the supervising dentist, and in the event of a referral for treatment, with dental offices.
- I understand that any diagnoses made by dentists who provide this service at school are done on a voluntary basis. No professional fees are charged and no professional reimbursement is received by any volunteer who participates in the school dental program as a service to community children. I understand that all volunteers are provided with limited liability under NH RSA 508:17.

☆ _____ _____

Parent/guardian signature **Date**

For dental use only: Examiner_____ Date_____