FORM for PreK- Grade 3

Learn more at:
www.ChildrensDentalNetwork.or

Dear Parent/Guardian,

The 2018-19 Salem Children's Dental Network (SCDN) 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 PreK-Gr. 3 children are encouraged to participate in dental screenings. A volunteer dentist or SCDN dental hygienist will screen participating students' teeth and written results will be sent home.

ALL PARENTS for PreK- grade 3: *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 K-3 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 the section below and *sign on reverse*.** Treatments may include **cleanings, fluoride varnish, sealants, decay stopping fluoride and temporary fillings**. There is no drilling. Sealants are coatings that help prevent cavities usually on the chewing surfaces of teeth. Decay stopping fluoride, for back teeth only, helps stop a cavity from getting bigger and makes it feel better. (also called SDF- silver diamine fluoride) Temporary fillings are coatings that slow or stop decay giving you time to schedule a dental appointment.

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 so, 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 & SIGN FORM

If your child has NH Medicaid, there is no charge for treatment and SCDN 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 Salem Children's Dental Network **to treat my child**, with a **screening**, **cleaning, fluoride treatment, 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 under direct supervision by Salem 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 Salem 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_____________

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