Learn more at:
www.ChildrensDentalNetwork.org

Dear Parent/Guardian,

The 2016-17 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. SCDN will provide in-school dental services for Salem students through Gr. 8 during the school year.
IF YOUR STUDENT VISITS A DENTIST ROUTINELY, PLEASE DO NOT RESPOND.

***IF your student is not able to receive preventive dental treatments** and you would like him/her to be treated at school, complete, sign the reverse, **and return this form promptly.** Return to school nurse or mail to: Children's Dental Network, Derry Village School, 28 S. Main St., Derry, NH 03038.

Salem Children's Dental Network provides in-school dental treatments that may include **cleanings, fluoride treatments, sealants, and temporary fillings**. There is no drilling. Sealants are coatings that help prevent cavities on the chewing surfaces of teeth. Temporary fillings are coatings that slow or stop decay giving you time to schedule a dental appointment.

Student's Name _____ School _____

M__ F__ Date of Birth ___/_____/____ Grade _____ Teacher _____

Parent or Guardian: _____ Address:_____

Day phone _____ Cell Phone _____ E-Mail _____ Best way to reach you? _____

Does your child have a dentist? _____ Last visit to dentist _____ What was done? _____ Next visit?_____

Anything else you want us to know? _____

1. **Does your child have a congenital heart defect that requires 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? Please check all that apply**.
☐ Can't find a dentist who accepts student'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
Does your student have Dental insurance? ☐ Yes ☐ No If yes, which kind of dental insurance:

☐ Private insurance If yes, which kind? _____
☐ 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!!***

Number in family	Monthly income equal to or less than	Cost		Monthly income between	Cost		Monthly income equal to or greater than	Cost
2	$2,670	Free		$2,671 – 4,004	$10		$4,005	$20
3	$3,360	Free		$3,361 – 5,039	$10		$5,040	$20
4	$4,050	Free		$3,051 – 6,074	$10		$6,075	$20
5	$4,740	Free		$4,741 – 7,109	$10		$7,110	$20
6	$5,430	Free		$5,431 – 8,144	$10		$8,145	$20
7	$6,122	Free		$6,123 – 9,182	$10		$9,183	$20
8	$6,815	Free		$6,816 – 10,222	$10		$10,223	$20

Read the attached Notice of Privacy Practices.

☆ Read and sign this informed consent.

- **I hereby give permission** for the Salem Children's Dental Network **to treat my child**, this school year, with **a screening, cleaning, fluoride treatment, sealants, and temporary fillings as needed.**
- **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 student's tooth or teeth if my student 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 charitable immunity under NH RSA 508:17.

_____ _____

Signature of Parent or Guardian **Date**

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