FORM for grades 4-8

Learn more at:
www.ChildrensDentalNetwork.org

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. SCDN will provide in-school dental services for Salem students grade 4-8 during the school year.
***IF YOUR STUDENT VISITS A DENTIST ROUTINELY, DO NOT RESPOND**.

IF your student <u>is not able to receive preventive dental treatments</u> 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 varnish treatments, dental sealants, decay stopping fluoride and temporary fillings**. <u>There is no drilling</u>. Sealants are coatings that help prevent cavities 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) You can tell it worked if cavity becomes hard and black over time. 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? <u>Please check all that apply</u>.**
   ☐ 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 <u>as they appear on the card</u>**
   Child's Name _____ Medicaid ID number ☐☐☐☐☐☐☐☐☐☐☐

✎ <u>TURN OVER & SIGN FORM</u>

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	$2,743	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.

☆ Read and sign this informed consent for treatment.

- **I hereby give permission** for the Salem Children's Dental Network **to treat my child**, this school year, with **a screening, cleaning, fluoride varnish 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 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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