FORM FOR PreK- Grade 8
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,

If your student is **not able to have preventive care in a dental office, complete the "YES" box and all the sections below and sign on reverse**. In school dental treatments include toothbrush cleaning, topical fluoride varnish, decay-stopping fluoride, dental sealants, and temporary fillings. There is no drilling, no shots and no pain. 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/or spring visits.

Student's Name ___________________ ☐M ☐F Teacher ________ Grade_____ School ______

☐ **YES**, I want my child to participate and receive school dental services.

Parent/Guardian__________________________________ Day Phone__________________ cell _____________

Does your child have a dentist? _________ Date of last dental visit? ___________ Next visit? _____________

* ***Please complete information below, provide parent or guardian signature and date on the back of this form and return to school promptly. Thank you.***

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 ☐☐☐☐☐☐☐☐☐☐☐

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 voluntary 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	$2,873	Free		$2,874 - $4,309	$10		$4,310	$20
3	$3,620	Free		$3,621 - $5,429	$10		$5,430	$20
4	$4,367	Free		$4,368 - $6,549	$10		$6,550	$20
5	$5,113	Free		$5,114 - $7,669	$10		$7,670	$20

Please read, sign and date Informed Consent Below

- **I hereby give permission** for the Children's Dental Network **to treat my child during this school year**, with dental assessment, 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 2020-21 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.
- **I understand that** any child in PreK – Grade 8 without access to dental care is welcome to participate. A CDN registered dental hygienist certified in public health will provide treatment and an assessment of your child's teeth. Written results will be sent home to parents and guardians. (in some cases, a senior dental hygiene student from NHTI or senior dental student from UNE, under direct supervision by Children's Dental Network, will provide treatment)
- **I understand that the services provided at school cannot replace regular examination and treatment in a dental office.** Routine care in a dental office is recommended.
- **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. **Privacy policy if found at:** www.childrensdentalnetwork.org
- **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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