FORM FOR PreK- Grade 8
Call 434-2327 or learn more at:
www.ChildrensDentalNetwork.org

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 a dental cleaning, brushing instruction, 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 the cavity becomes hard and black over time. This permission is for fall and/or spring visits.

If your child DOES NOT visit the dentist routinely, please complete this form

Student's Name ________________________ ☐M ☐F Teacher____________ Grade___ School ________

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

Parent/Guardian name _____________________________________ phone_________________________

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

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

Child's Date of Birth ____/_____/____ Address____

What is the best way to reach you? ________________ Cell phone____________________ Email __________________________

1. **Does your child have a congenital heart defect requiring pre-medication with antibiotics before dental care?** ☐ 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 your child 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 ☐ 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 ☐☐☐☐☐☐☐☐☐☐☐

There is no fee for school dental care. If your child has Medicaid, CDN will bill Medicaid.

*Please provide parent signature on reverse if participating

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 2023-24 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. ***The NEXT Charter School (grade 9-12) is included in our program.***
- **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 only if my child cannot be identified in 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 is 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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