FORM for PreK- Grade 12

Learn more at:
www.ChildrensDentalNetwork.org

Dear Parent/Guardian,

If your student is not able to have preventive care in a dental office, complete the "YES" box and all the remaining sections of the form (both sides). In school dental treatment may include toothbrush cleaning, fluoride varnish, sealants, decay stopping fluoride and temporary fillings. There is no drilling, no shots and no pain. Sealants are coatings that help prevent cavities usually on the chewing surfaces of teeth. The 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.

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 on the back of this form and return to school promptly. *Thank you.*

Parent Cell Phone ____________________ Parent E-Mail ________________________ 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 ☐☐☐☐☐☐☐☐☐☐☐

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 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 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 2020-21 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.
- **I understand that** any child in PreK - Grade 12 without access to dental care is welcome to participate. A SCDN registered dental hygienist certified in public health will provide dental treatment and an assessment of your child's teeth. Written results will be sent home.
- **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. **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____________

2	3	4	5	6	7	8	9	10	11	12	13	14	15
		a	b	c	d	e	f	g	h	i	j		
		t	s	r	q	p	o	n	m	l	k		
31	30	29	28	27	26	25	24	23	22	21	20	19	18