

Community Health Administration

Dear Parent or Guardian:

The District of Columbia Department of Health (DOH) is sponsoring preventive dental services at your child's school through the DOH School-Based Oral Health Program. Licensed dentists and their staff will provide exams ("checkups") and x-rays to students who have not seen a dentist in the last six (6) months. The services will include: dental cleanings, fluoride treatments, and sealants (as needed). Students that need services not offered at the visit (such as fillings, tooth removal, or braces) will be referred to community dentists. Services do not include drillings or shots. Information from your child's visit will be shared with the school nurse or other point of contact at the school and with the DOH School-Based Oral Health Program for the purposes of: billing, treatment and follow-up, and program monitoring.

PLEASE NOTE: Children should see their dentists every six (6) months. If a child has a regular dentist, the School-Based Oral Health Program services should NOT take the place of a visit to that dentist. If a child has been to the dentist in the last six (6) months, she or he may not need the school-based services. The dental providers will check for dental insurance coverage and the last dental visit for all children to be seen at the school and will bill insurance for any services provided.

(Student Name) (Date of Birth) Female Male

(Home Street Address) (Apt #) (Zip Code) (School Grade)

School Name: Teacher Name:

Parent/Guardian Name: Phone:

Email: Other Phone:

Health Insurance - You must select one of the checkboxes and provide all related information in order for your child to receive services.

This child has the following Medicaid/Healthy Families insurance plan:

DC Healthy Families DC Medicaid AmeriHealth Caritas Amerigroup D.C. Trusted Health
Other:

Medicaid/DC Healthy Families #:

This child has private dental insurance:

Insurance Company Name: Insurance Phone:
Employer Name: Employer Phone:
Name of Insured Adult: Birthdate of Insured Adult:
Member ID/Policy #: Group #:

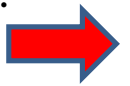
This child does not have any dental insurance.

Last Dental Visit: 1-3 months 4-6 months More than 6 months Not Sure Never seen a dentist

I have read the notice on the back of this page and understand and agree to its terms. By signing, I give my informed consent for my child to receive services through the DOH School-Based Oral Health Program.

Parent/Guardian Signature

Date



Please complete important health information on the back

Community Health Administration

As the parent/guardian of the above-named student, I consent for him/her to receive dental services through the DOH School-Based Oral Health Program. I understand that consent to my child’s participation provides consent for the following:

- The dental provider to verify insurance before services are provided;
- The dental provider to bill & collect payment from any Medicaid, private insurance, or other payer.
- If I have private dental insurance, the dental provider to bill the family for any deductibles and/or copays.
- The dental provider to confidentially share my child’s clinical information with the Department of Health, Department of Health Care Finance, Medicaid Managed Care Organizations (MCO), and/or other clinical providers involved in my child’s health care.

Further, I agree to discharge, indemnify, and hold harmless the District of Columbia and any agency, employee, officer, agent or representative of the District of Columbia from all claims, demands, actions, or judgments which I or my heirs, executors, administrators, or assigns may have for any and all injuries and damages, known or unknown, caused by or arising from the activities listed above. **I understand that if I fail to sign this consent form, my child will not receive any services offered under this program.**

I understand I may revoke this consent at any time by providing written notice to Justice Armattoe at the DC Department of Health (899 N. Capitol St. NE, 3rd Floor, Washington, DC 20002). I further understand that until this revocation is made, the consent for services shall remain in effect for one calendar year from the date it is signed, and my child’s information will continue to be accessible by the parties listed above for the specific purposes described.

Please provide the following information to help the dental provider best serve your child:

Student Name: _____

MEDICAL INFORMATION - Check each condition that applies to your child and explain in the space provided.

Dental problems: _____

Heart problems/valve replacements/shunts: _____

Asthma/breathing problems: _____

Epilepsy/seizures: _____

Allergies: _____

Latex allergy: _____

Pine Nut allergy: _____

Acrylic allergy: _____

Current medications: _____

Antibiotic premedication required? _____

Other health problems (i.e., diabetes, bleeding problems, communicable diseases, etc.)?

Does your child have a usual dentist? If yes, please give dentist’s or dental practice’s name:

Does your child have a usual medical/primary care doctor? If yes, please give doctor or medical practice’s name:
