DC | HEALTH

Government of the District of Columbia
Department of Health

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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.

_____ _____ ☐ Female ☐ Male
(Student Name) (Date of Birth)

_____ _____ _____ _____
(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

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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: _____