

For more information, call 434-2327
www.ChildrensDentalNetwork.org



Working Together for Healthier Kids

Dear Parent/Guardian of a student gr. 3-8,

Children’s Dental Network, funded since 1993 by the Alexander Eastman Foundation, offers in-school dental services again in 2015-16.

If your student visits a dentist routinely, do not respond.

IF your student is not able to receive preventive dental treatments and you would like him/her to be treated at school, complete, sign the reverse, and **return this form promptly** to school OR mail to CDN business office: Children’s Dental Network, 28 S Main St, Derry, NH 03038

Children’s Dental Network provides cleanings, fluoride treatments, sealants, and temporary fillings. There is no drilling. Sealants are coatings that help prevent cavities on the chewing surfaces of teeth. Temporary fillings are coatings that slow decay while treatment in a dental office is being arranged. We hope to provide services twice this school year. This permission form is for both visits.

Student’s Name _____ School _____

M__ F__ Date of Birth __/__/__ Grade _____ Teacher _____

Parent or Guardian: _____ Address: _____

Day phone _____ Cell Phone _____ Best way to reach you? _____

Does your child have a dentist? _____ Last visit to dentist _____ What was done? _____ Next visit? _____

Anything else you want us to know? _____

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? Please check all that apply.**
 Can’t find a dentist who accepts student’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
Does your student have Dental insurance? Yes No If yes, which kind of dental ins.?
 Private insurance
 Medicaid – **If yes, clearly write name and Medicaid ID number as they appear on the card:**

Child’s Name _____ Medicaid number

Turn over – signature required

If your child has Medicaid, there is no charge for treatment and CDN will bill Medicaid. Please use the table below to determine your suggested 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!

Children’s Dental Network is 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.

Number In Family	Monthly income equal to or less than	Cost	Monthly income between	Cost	Monthly income equal to or greater than	Cost
2	\$2,655	Free	\$2,656 - 3,981	\$10	\$3,982	\$20
3	\$3,348	Free	\$3,349 - 5,021	\$10	\$5,022	\$20
4	\$4,041	Free	\$4,042 - 6,061	\$10	\$6,062	\$20
5	\$4,735	Free	\$4,736 - 7,101	\$10	\$7,102	\$20
6	\$5,428	Free	\$5,429 - 8,141	\$10	\$8,142	\$20
7	\$6,121	Free	\$6,122 - 9,181	\$10	\$9,182	\$20
8	\$6,815	Free	\$6,816 - 10,221	\$10	\$10,222	\$20

Read the Notice of Privacy Practices.

★ Read and sign this informed consent.

- **I hereby give permission** for the Children’s Dental Network **to treat my child, twice** this school year, with a screening, cleaning, fluoride treatment, sealants, and temporary fillings as needed.
- **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 Children’s Dental Network) will provide the services.
- **I understand that a photograph** may be taken of my student’s tooth or teeth if my student 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.
- 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 protected with limited liability under NH RSA 508:17.



Signature of Parent or Guardian

Date