Alice Peck Day Memorial Hospital *Upper Valley Smiles*

Canaan Elementary School Consent Form 2016-2017

Dear Parent/Guardian,

During this school year, a dental program is being offered in the Canaan Elementary School for children in grades preK-4 who are not able to receive regular preventive dental care. A volunteer dentist or an *Upper Valley Smiles* certified public health dental hygienist will assess your child's teeth and results will be sent home.

ALL PARENTS: please complete and return this form by Friday, Sept. 16th

Child's Name _____ ☐**M** ☐**F** **Teacher**_____

☐ **NO,** I do not want my child to participate. Signature. _____

Do not continue. Please return form. Thank you.

Preventive services will include: a toothbrush cleaning, topical fluoride varnish, decay-stopping fluoride treatment, dental sealants and temporary fillings. Sealants are coatings that help prevent cavities on the chewing surfaces of the teeth. Temporary fillings are coatings that slow dental decay until treatment in a dental office can be arranged. Decay-stopping fluoride treatments, for back teeth only, help stop a cavity from getting bigger and make it feel better. You can tell it worked if the cavity becomes hard and black over time. This treatment may need to be repeated in 6-12 months.

☐ **YES**, I want my child to receive a dental assessment, and if eligible, a toothbrush cleaning, dental sealants, topical fluoride varnish, decay- stopping fluoride treatment and temporary fillings, as needed. Complete questions below, turn form over and **sign on back**.

Please Print: Parent/Guardian_____ Day Phone_____

Does your child have a dentist? ____ Dentist name_____ Date of last dental visit? _____Next visit_____

Cell Phone _____ 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 If yes, explain _____ ☐ No

3. **Has your child ever had any serious health problems?** ☐ Yes _____ ☐ No

4. **Does your student have medical insurance?** ☐ Yes ☐ No **Dental insurance?** ☐ Yes ☐ No If so, which kind of dental insurance?
   ☐ Name of private dental insurance: _____
   ☐ NH Medicaid – If yes, clearly **print child's name and Medicaid ID number <u>as they appear on the card:</u>**

   Child's Name _____ **Medicaid** ID number: __ __ __ __ __ __ __ __ __ __ __

SIGN FOR ASSESSMENT and/or PREVENTIVE TREATMENT ON REVERSE SIDE

If your child has NH Medicaid, APD will bill Medicaid and there is no charge to you for services. Please use the table below to determine your suggested contribution if your child is not covered by Medicaid. Please make checks payable to: APD Upper Valley Smiles. **No child will be denied service if unable to afford fees.**

Number in family	Monthly income equal to or less than	Cost		Monthly income between	Cost		Monthly income equal to or greater than	Cost
2	$2,670	Free		$2,671 – 4,004	$10		$4,005	$20
3	$3,360	Free		$3,361 – 5,039	$10		$5,040	$20
4	$4,050	Free		$4,051 – 6,074	$10		$6,075	$20
5	$4,740	Free		$4,741 – 7,109	$10		$7,110	$20

Read the attached Notice of Privacy Practices and Sign Consent Below

I hereby give permission for the APD Upper Valley Smiles staff to provide this student with a dental assessment, and if eligible, provide a toothbrush cleaning, dental sealants, fluoride varnish, decay-stopping fluoride and temporary fillings as needed. **I understand** that the services provided at school cannot replace regular examination and treatment in a dental office.

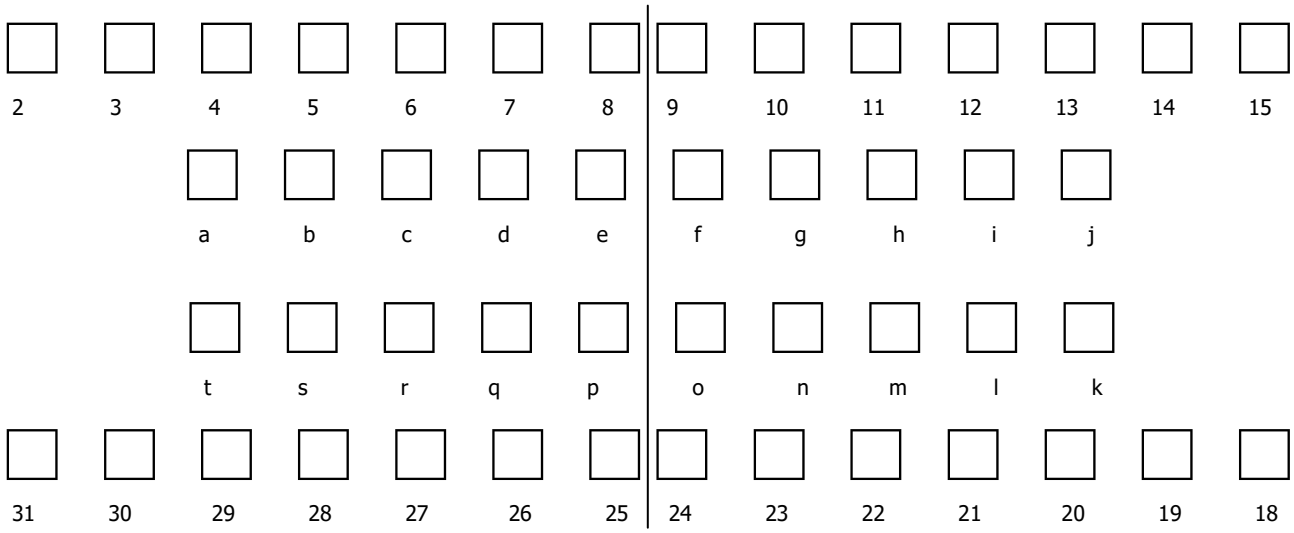
I have received and read APD's Notice of Privacy Practices and understand that you may share the results of my child's dental assessment for further treatment, and payment activities with the school nurse, supervising dentist and dental offices if referral for treatment is needed. Additionally, the results of your child's dental assessment will be added to a central secured data base to be included in an ongoing assessment of children's dental health for the state of NH. You may provide my contact information to the APD Upper Valley Smiles Care Coordinator, in case of further dental need follow up.

☆_____ _____

Parent/guardian signature **Date**

Dental use only: Dentist/RDH_____ Date _____ OH: A B C

Code: **D** Decayed **D/T** Temp Filling **X** Missing **F** Filled **G** Normal **R** Rec Sealant **S** Sealed **RF** Rec Silver Diamine Fluoride



For more information, call your school nurse