Pre-Gr.2

Call 434-2327 or learn more at:
www.ChildrensDentalNetwork.org

CHILDREN'S Dental NETWORK
Working Together for Healthier Kids

ALEXANDER EASTMAN FOUNDATION

Dear Parent/Guardian,

The 2015-16 Children's Dental Network (CDN) 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. **ALL children are encouraged to participate in screenings.** A volunteer dentist or CDN hygienist will screen participating students' teeth and written results will be sent home.

ALL PARENTS for preschool - 2nd grade: *please* respond and return this form promptly.

Student's Name _____ ☐**M** ☐**F** **Teacher** _____ **School** _____

☐ **NO,** I do not want my child to participate. Signature. _____
Do not continue. Please return form. Thank you.

☐ **YES**, I want my student screened. All Preschool – 2nd gr. students are welcome.

Parent/Guardian_____ Day Phone_____ Grade _____

Does your child have a dentist? _____ Date of last dental visit? _____ Next visit? _____

Signature _____ Date _____

If your child receives routine dental care, do not continue. *Return form. Thank you.*

If your student is not able to have preventive care in a dental office, complete the screening permission above and this section and sign on reverse. Treatments include cleanings, fluoride, sealants, and temporary fillings. There is no drilling. This permission is for fall and spring treatments.

Cell Phone _____ E-Mail _____ What is 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 ☐☐☐☐☐☐☐☐☐☐☐

SIGN FOR TREATMENT ON REVERSE

If your child has NH 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!!

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 attached Notice of Privacy Practices and Sign Consent Below

- **I hereby give permission** for the Children's Dental Network **to treat my child twice this school year,** with 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 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 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 provided with limited liability under NH RSA 508:17.

☆ _____ _____

Parent/guardian signature **Date**

For dental use only: Examiner_____ Date_____

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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31	30	29	28	27	26	25	24	23	22	21	20	19	18	