GREENUP COUNTY HEALTH DEPARTMENT SCHOOL HEALTH DENTAL PROGRAM

*** THIS FORM MUST BE FILLED OUT COMPLETELY FOR YOUR CHILD TO PARTICIPATE***

With your **permission**, a public health registered dental hygienist will provide your child with:

•A dental assessment of the condition of the mouth and teeth •A professional dental cleaning

•Fluoride varnish •Oral hygiene instruction including nutritional counseling

•Dental sealants (protective coating on the chewing surface of molars) •Report card, including follow up information

This program does **NOT** take the place of regular check-ups at a dental office. The preventive dental services are being done by a Public Health Registered Dental Hygienist without the on-site presence of a dentist, according to KRS 313.040. The Dentist Board member for the Greenup County Health Department is supportive of the standards of practice of the public health hygienists and works with the Greenup County Health Department to develop and adopt protocols for these services.

(Check One) ◯ **YES,** I want my child to have preventive dental services at school

◯ **NO,** I do not want my child to have preventive services at school **(if NO, Fill out Child's Name only)**

Parent/Legal Representative Name (Please Print) _____

Parent/Legal Representative Signature _____

Relationship to child_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Child's Name: _____ (Select one) ◯ Male ◯ Female

Child's Address:_____ **City:**_____ **County:**_____ **Zip Code:**_____

Date of Birth: ____/____/_____ **Child's Social Security Number** _____-_____-_____

School _____ **Grade**_____ **Teacher/Homeroom Teacher:** _____

What is your child's race: (Select all that apply)

- American Indian/Alaskan Native ☐ - Pacific Islander **Ethnicity:** ☐ -Hispanic or Latino ☐ - Asian

☐ - White ☐ -Black or African American

Does your child have Medicaid? (Select one) ◯ YES or ◯ NO (**Medicaid will be billed for preventive services)**

Medicaid 10 Digit ID# _____ MCO # _____

Please mark which Managed Care Company you belong to with Medicaid:

Aetna Better Health of KY _____ **WellCare** _____ **Passport** _____ **Humana CareSource** _____

Anthem _____

Does your child have private Dental insurance? ◯ YES or ◯ NO

NO Dental Insurance at this time_____

********PLEASE COMPLETE BOTH SIDES OF FORM********

REVISED ON 07/09/2025

Child's Name_____ **DOB**_____

Dental History:

Has your child been seen in the same dental office twice in the past two years? (Select one) ◯ YES or ◯ NO

Dentist's Name _____

Is your child experiencing dental pain at this time? (Select one) ◯ YES or ◯ NO

When was the last time your child went to the dentist? Select one below.

In the past year ◯_____ More than one year ago ◯_____ In the past six months ◯_____

Never ◯_____

Health History: Child's Medical Doctor _____ Phone #_____

Please select if your child has ever had: ☐ Heart Murmur ☐ Latex Allergy ☐ Other allergy _____

☐ Asthma ☐ Seizures/Epilepsy ☐ Diabetes ☐ Cancer/Chemotherapy ☐ Heart Problems (please explain) _____

Please list any other medical conditions (past or present) _____

Please list *all* current medications taken regularly _____

CONSENT FOR HEALTH SERVICES: (Expires 1 year from date signed)

Of my own free will I consent to care which may include, assessments, professional cleanings, sealants, fluoride varnish and any other health service given to me by staff or agents of this health department. I understand that no guarantees are being made as to the effect of any assessments or treatment on me. I also understand I may be tested for (HIV) infection, Hepatitis B, or any other disease carried by blood or body fluids if a health care worker is exposed to my blood, body fluids or tissue.

This consent authorizes our providers to share pertinent information to ensure continuity of care. We may use medical information to provide, coordinate or manage your health care. We may consult with other health care providers, school administration, FRYSCs (Family Resource and Youth Service Centers) and/or MCO patient care coordinators concerning your or your child's need for care. Each party that is given personal health information is also bound by their signed agreements (HIPAA or FERPA) with their respective employers.

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This form, when signed and filled in, contains Protected Health information and the information is to be protected according to the health Insurance Portability and Accountability ACT (HIPAA). **NOTICE OF PRIVACY:** Notice of Privacy is available upon request.

****My signature below acknowledges my receipt of the health department's "**NOTICE OF PRIVACY PRACTICES**" on the date stated.*

I understand that my child may be screened to check the retention of dental sealants by the public health dental hygienist during the following school year.

_____ _____

Signature of Parent/Guardian or other Authorized Person *Date Signature of Patient or Other Authorized Person*

Please sign and date this section if you have Medicaid

******(Must be signed by legal guardian, if child is in foster care-**Case Worker MUST sign)******

PAYMENT FOR SERVICE/ASSIGNMENT OF BENEFITS

☐ ASSIGNMENT OF BENEFITS: I request that payment of authorized medical insurance benefits be made to the local health department on my behalf, for services received. I also authorize the local health department to release medical information about me to Medicare, Insurance and other third party payors to determine payment for services.

I have read the above and have had an opportunity to ask questions. I understand the above statement as it applies to me and my child. My signature below indicates I do consent, authorize or declare as stated above.

➡

_____ _____

Signature of Parent/Guardian or other Authorized Person *Date Signature of Patient or Other Authorized Person*

Please return to your child's classroom teacher or school nurse

******(Must be signed by legal guardian, if child is in foster care-**Case Worker MUST sign)******