Greenup County Health Department

With your permission, a registered public health dental hygienist will provide your child with the following services:

- A dental assessment to evaluate the condition of the mouth and teeth
- A professional dental cleaning
- Fluoride varnish application
- Oral hygiene instruction and nutritional counseling
- Dental sealants (a protective coating applied to the chewing surfaces of molars)
- A dental report card summarizing your child's oral health

This program does ***NOT*** replace regular dental check-ups with your child's dentist. Preventive services are provided by a Public Health Registered Dental Hygienist without a dentist on-site, in accordance with Kentucky law (KRS 313.040). The Greenup County Health Department works in collaboration with a consulting dentist, who supports the standards of practice for public health hygienists and helps develop and approve care protocols. Every child can receive dental care, no matter their insurance status. There is no cost to students or their families. Medicaid will be billed for these preventive services. These services are covered under Medicaid's medical benefits for health departments and will not affect your child's regular dental benefits or routine dental visits.

If you have any questions please contact The Greenup County Health Department (606) 473-9838 EXT 144 or 145.

(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)**

Parent/Legal Representative Name (Please Print) ____

Parent/Legal Representative Signature ____

Relationship to child______________________________________

Home Phone: ____________________ **Cell Phone:** _________________ **Work Phone:** ___________

Child's Name: ____ (Circle one) Male Female

Child's Address:________________________ **City:**_____________ **County:**____________

Zip Code:_________

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

School __________________________ **Grade**________ **Teacher/Homeroom Teacher:** ________________

*****PLEASE COMPLETE ALL PAGES *****

Child's Name___________________________________ **DOB**_______________________

What is your child's race? *(Check all that apply)*

☐ American Indian / Alaskan Native
☐ Asian
☐ Black or African American
☐ Pacific Islander
☐ White

Ethnicity: *(Check one)*

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Does your child have Medicaid? *(Circle one)*
YES / NO
(Medicaid will be billed for preventive services)

Medicaid 10-Digit ID #: ____________________________
MCO #: ____________________________

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

☐ Aetna Better Health of KY
☐ WellCare
☐ Passport / Molina
☐ Humana CareSource
☐ United Healthcare

Does your child have private dental insurance? *(Circle one)*
YES / NO

NO dental insurance (*Check if this applies)* ☐

Dental History:

Has your child been seen in the same dental office twice in the past two years? *(Circle one)*
YES / NO

Dentist's Name: ____________________________

Is your child currently experiencing dental pain? *(Circle one)*
YES / NO

When was your child's last dental visit? *(Check one)*

☐ Within the past 6 months
☐ Within the past year
☐ More than one year ag
☐ Never

Health History:

Child's Medical Doctor: ___________________________
Phone Number: ___________________________

Please indicate if your child has ever had any of the following: *(Circle all that apply)*

- 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 your child takes 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 cleaning, 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.

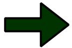
This consent authorizes our providers to share pertinent information to ensure continuity of care. We may use medical information to provide, coordinate or manage your health care. We may consult with other health care providers, school administration, FRYSCs (Family Resource and Youth Service Centers) 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.

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, Dr Tim Strait, DMD, is supportive of the standards of practice of public health hygienists. The KY State Dentist, Dr. Julie McKee, DMD, works with the Greenup County Health Department to develop and adopt protocols for these services.

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 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)******

REVISED ON 5/7/2026