

SCHOOL BASED DENTAL CENTERS ENROLLMENT FORM & INFORMATION

Dorchester County Schools

Dear Parent/Guardian:

As a student in the Dorchester County Public School system, your child has access to the Choptank Community Health SCHOOL BASED DENTAL PROGRAM.

The mission of the Program is to **improve the health of students, increase access to primary health care and decrease time lost from school by providing care** within the school setting. We are a **convenient source of quality health care** that works in collaboration with your child's doctor and the school nurse.

Choptank Community Health recognizes the connection between health and positive academic outcomes. CCHS is pleased to partner with Dorchester County Public Schools and Dorchester County Health Department to ensure that students are healthy and ready to learn.

SERVICES AVAILABLE IN THE SCHOOL BASED DENTAL PROGRAMS

As a student in the **Dorchester** County Public School system, your child has access to the **School Based Dental Program**. The program is a partnership between the Public Schools, County Health Departments and Choptank Community Health System (CCHS).

Services may include:

- Dental screening for cavities
- Dental cleaning & polishing
- Fluoride application to help prevent or slow the progression of cavities (may be applied twice)
- Protective sealants on molar teeth
- Oral Health Education to better care for teeth
- Dental emergency referrals to Dentists or Doctors

The School Based Dental Program does not take the place of your primary dentist. A dental hygienist will screen your child to determine which services will be provided or if a referral is necessary. The hygienist provides care in the school setting that promotes healthy teeth and gums. Your child should go to your dental office for a complete exam with x-rays as often as recommended by your dentist.

If you have any questions about the program, please contact CCHS at (410) 479-4306, ext.1038

Oral Health Goals



Floss Daily



**Drink tap water
(containing fluoride)**



Eat healthy snacks



The last thing to touch
your child's teeth before
bed is the toothbrush!



SCHOOL BASED DENTAL PROGRAM

2020-2021 ENROLLMENT/UPDATE FORM

DENTAL SERVICES AT SCHOOL

My child is a student at: _____ Grade: _____ Homeroom Teacher: _____

<u>STUDENT INFORMATION</u>	
NAME: _____	
ADDRESS: _____ _____	
DOB: _____	AGE: _____ Male / Female
SOCIAL SECURITY #: _____	
RACE: _____	HISPANIC/LATINO?: YES / NO
PREFERRED LANGUAGE: _____	
DOCTOR: _____	PHONE: _____
DENTIST: _____	PHONE: _____
PHARMACY: _____	PHONE: _____

<u>PARENT/GUARDIAN INFORMATION</u>	
NAME: _____	
RELATIONSHIP: _____	
PREFERRED LANGUAGE: _____	
#1 PHONE: _____	
#2 PHONE: _____	
EMAIL: _____	
Student Lives With: _____	
EMERGENCY CONTACT: _____	
RELATIONSHIP: _____	
PHONE: _____	PHONE: _____

<u>DENTAL INSURANCE</u>	
INSURANCE NAME: _____	POLICY/MEMBER ID#: _____
SUBSCRIBER NAME: _____	GROUP #: _____
CLAIMS ADDRESS: _____	

 I want to enroll my child in the School Based Dental Program

I understand that my signature gives consent for the CCHS School Based Dental Program Providers to treat my child and to communicate with my child's primary health care provider. I give CCHS permission to call my home, leave a message on a machine or with a person regarding healthcare information. I understand that my child's health information will be used for treatment, payment and health care operations. CCHS may also mail healthcare information to my home. I recognize that school directories may be used to obtain information left blank on the enrollment form. My child's immunization record may be shared between the School Nurse and the School Based Dental Program. For the purposes of care coordination and case management School Clinical Staff will have access to the SBDP health records and School Clinical Staff shall share health information with the SBDP staff, and. School Clinical Staff are required to treat the information in the SBDP health record as confidential and comply with the HIPAA Privacy Rule. Under no circumstances, do SBDP records become part of the student's school health record. I understand that services provided to my child will be billed to my insurance carrier or Medical Assistance. I may receive a bill from CCHS for copays and/or deductibles. I understand that my signature indicates that I have had the opportunity to receive and review the Choptank Community Health's Notice of Privacy Practices. If I do not have insurance, I will be billed for the full cost of services or with a sliding fee discount if applicable.

Parent/Guardian Signature: _____ Date: _____

PLEASE COMPLETE HEALTH HISTORY INFORMATION

Office Use:	LC:	NA:	INS.	E	I	SF
	OHI	Prophy	FL2		Sealants	

Office Use:
<input type="checkbox"/> Posted <input type="checkbox"/> Scanned
Date Entered: _____

STUDENT Name: _____

DOB: _____

DENTAL HEALTH HISTORY

LIST ALL MEDICATIONS YOUR CHILD TAKES ON A DAILY BASIS:

MEDICATION: _____ DOSE: _____ mg DIRECTIONS: _____
 MEDICATION: _____ DOSE: _____ mg DIRECTIONS: _____
 MEDICATION: _____ DOSE: _____ mg DIRECTIONS: _____

YES / NO MY CHILD HAS MEDICATION / FOOD / ENVIRONMENTAL ALLERGIES?
 IF YES, PLEASE LIST: _____

YES / NO HAS YOUR CHILD HAD ANY RECENT HOSPITALIZATIONS OR SURGERIES?
 IF YES, PLEASE LIST: _____

YES / NO DOES ANYONE SMOKE IN THE HOME? YES NO DRUGS/ALCOHOL ADDICTION

YES / NO HAS YOUR CHILD COMPLAINED OF DENTAL PAIN IN THE PAST SIX MONTHS?

YES / NO HAS YOUR CHILD SEEN A DENTIST WITHIN THE PAST SIX MONTHS? Last Visit?: ____/____/____

**If your child has a heart condition, please attach a medical clearance letter to the enrollment form.*

STUDENT HISTORY

HAS CHILD EVER HAD ANY OF THE FOLLOWING?
 (circle "yes" or "no")

- YES NO ADD/ADHD
- YES NO ANEMIA
- YES NO ASTHMA/BREATHING
- YES NO BLOOD DISORDER
- YES NO CANCER
- YES NO DEVELOP. DISABILITY
- YES NO DIABETES
- YES NO HEADACHES/MIGRAINE
- YES NO HEARING/VISION
- YES NO HEART PROBLEMS
- YES NO HIGH BLOOD PRESSURE
- YES NO HIV/AIDS
- YES NO KIDNEY/BLADDER
- YES NO LEAD POISONING
- YES NO LIVER PROBLEMS
- YES NO MENTAL ILLNESS
- YES NO OBESITY
- YES NO SEIZURES/EPILEPSY
- YES NO SKIN PROBLEMS
- YES NO STOMACH PROBLEMS
- YES NO STROKE
- YES NO THYROID PROBLEMS
- YES NO TOOTH DECAY
- YES NO TUBERCULOSIS

OTHER: _____

FAMILY HISTORY

HAS AN IMMEDIATE FAMILY MEMBER (parent, sibling, grandparent) EVER HAD
 ANY OF THE FOLLOWING? (circle "yes" or "no")

- YES NO ADD/ADHD Who?: _____
- YES NO ANEMIA Who?: _____
- YES NO ASTHMA/BREATHING Who?: _____
- YES NO BLOOD DISORDER Who?: _____
- YES NO CANCER Who?: _____
- YES NO DEVELOP. DISABILITY Who?: _____
- YES NO DIABETES Who?: _____
- YES NO HEADACHES/MIGRAINE Who?: _____
- YES NO HEARING/VISION Who?: _____
- YES NO HEART PROBLEMS Who?: _____
- YES NO HIGH BLOOD PRESSURE Who?: _____
- YES NO HIV/AIDS
- YES NO KIDNEY/BLADDER Who?: _____
- YES NO LEAD POISONING Who?: _____
- YES NO LIVER PROBLEMS Who?: _____
- YES NO MENTAL ILLNESS Who?: _____
- YES NO OBESITY Who?: _____
- YES NO SEIZURES/EPILEPSY Who?: _____
- YES NO SKIN PROBLEMS Who?: _____
- YES NO STOMACH PROBLEMS Who?: _____
- YES NO STROKE Who?: _____
- YES NO THYROID PROBLEMS Who?: _____
- YES NO TOOTH DECAY Who?: _____
- YES NO TUBERCULOSIS Who?: _____

OTHER: _____

Additional Information: _____

PLEASE RETURN COMPLETED ENROLLMENT TO YOUR SCHOOL NURSE. THANK YOU!

Documented and reviewed by: _____