Dental Services at School!

OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

NATIVE AMERICAN **HEALTH CENTER**
Serving the community since 1972

LifeLong Medical Care
Health Services for All Ages

Return by: _______________ School: ___________________________________

Child's name: ____

Teacher's name: _________________________ Room#: ______ Grade: ______

About the dental program:

This dental program is supported by OUSD and Alameda County Office of Dental Health.

- **All students are eligible to receive dental services at no cost, regardless of insurance or legal status.** We can bill Medi-Cal or provide the same services free of charge to students with no insurance.
- All dental services are performed by licensed dental providers at the school. Your child will not miss any school days.
- You can choose what dental services you want your child to receive: dental exams, preventive services, and some dental treatments are available at school. In some cases, students may also be referred to a dental clinic.

How to get this dental care for your child:

To give your permission, please complete this consent form and return it to the school as soon as possible. Information on privacy practices, policies, and procedures are available at the school office and/or clinic.

☐ My child will NOT participate in this dental program

1. First tell us about you (parent/guardian)

Your first name: ________________________ Last name: ______________________

Are you the: ☐ Mother ☐ Father ☐ Other: ______________________

Your phone number: (   ) ______________ Cell phone: (   )________________

Your date of birth: *month:* _____________ *day:* __________ *year:* ______________

Your street address: _____________________________________ Apt. # __________

City: ____ Zip: ___________________

Language spoken at home: ____

2. Now tell us about the child who will receive dental care

(You must fill out a form for each child receiving dental care)

Child's first name: _______________________ Last name: _______________________

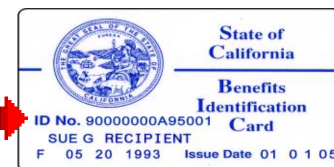
Child's gender/sex: ____

Child's date of birth: *month:* _____________ *day:* ________ *year:* _____________

Is this child: ☐ Hispanic/Latino ☐ African American ☐ White
☐ Native American ☐ Pacific Islander ☐ Asian
☐ Multi-racial ☐ Other: ____________ ☐ Decline to answer

3. Insurance information

What type of insurance does your child have?



☐ **No insurance at this time**

☐ **Medi-Cal** → please provide the Medi-Cal ID #

on the card: ________________________________

☐ **HealthPAC** ☐ **Other public insurance** ☐ **Private insurance**

4. Does this child have a dentist?

☐ **Yes** → Name of dentist or clinic ____

☐ **No**

When was the child's last visit to the dentist?

☐ Less than 6 months ago ☐ 6 months to 1 year ago
☐ More than 1 year ago ☐ Never been to the dentist

5. Is this child currently taking any medications?

This includes prescription medications and medications you can get without a prescription from the doctor.

☐ **No medications**

☐ **Yes**→ Please list the **name** and **purpose** of each medication:

____

____

Please fill out the front & back side of this form

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6. Has this child ever had any of these medical conditions?

If so, mark the boxes to show which ones.

- ☐ **No medical conditions**
- ☐ Asthma
- ☐ Diabetes
- ☐ Lung problems
- ☐ TB (tuberculosis)
- ☐ Heart problems
- ☐ ADD or ADHD
- ☐ Epilepsy or seizures
- ☐ Emotional disorders
- ☐ Hepatitis or other liver problems
- ☐ Rheumatic fever
- ☐ Kidney problems
- ☐ Sickle cell
- ☐ Hemophilia (a bleeding disorder)
- ☐ Something else: ______________________________

7. Does this child have any allergies?

- ☐ **No known allergies**
- ☐ Allergic to penicillin
- ☐ Allergic to peanuts
- ☐ Allergic to latex
- ☐ Other allergies or sensitivities to medications: ______________________

Reaction: ______________________________

8. Services that will be provided: Preventive Services

We must do a mandatory dental check-up (exam) to see what dental care your child needs. Dental X-rays are often a necessary part of the exam and can help locate cavities.

Do you give us permission to provide your child with the following services?

A dental check-up (exam) ☐ **Yes** ☐ **No**

Dental X-rays of your child's mouth ☐ **Yes** ☐ **No**

Do you give us permission to provide your child with the following kinds of **preventive dental care**?

- Dental Cleaning
- Fluoride treatment to help prevent cavities
- Dental sealants to help prevent cavities
- Tips on brushing and how to take care of their teeth

☐ **Yes**, I would like my child to receive any needed preventive services.

☐ **No**, I do not want my child to receive any preventive dental care.

9. Services that will be provided: Treatment Services

If the exam shows your child needs dental treatment, we will tell you. If needed, do you give us permission to provide your child with the following kinds of **treatment for cavities (tooth decay) or other dental problems**?

Cavity fillings using composite fillings (tooth-colored fillings) ☐ **Yes** ☐ **No**

Cavity fillings using amalgam fillings (silver-looking fillings) ☐ **Yes** ☐ **No**

Extractions to take out "baby" teeth ☐ **Yes** ☐ **No**

10. Do you want to be there when your child is getting dental care at school?

☐ **No**, I don't plan to come for the appointment. It's fine for my child to get the dental care whether I am there or not.

☐ **Yes**, I'd like to be there if I can. But if I can't come to the appointment, it is still okay to give the dental care.

☐ **Yes**, and I don't want my child to get dental care unless I am there.

11. Please read and sign below. By signing below, you consent to the following:

- **I give the clinics (Asian Health Services, La Clínica de La Raza, Lifelong Medical Care or Native American Health Center) permission to provide my child a dental exam and dental services I have marked "YES" to.**
- **I give the clinics permission to perform a second check-up 6 months to a year after treatment to check sealant retention and the oral health improvement of my child, if necessary.**
- **I give the clinics permission to share information as needed to bill Medi-Cal. I also give the clinics permission to share information with my child's school, OUSD and Alameda County Office of Dental Health.**
- **I understand that services will be provided at no cost to those who do not have any insurance.**
- **I understand that the clinics will follow their policies for protecting the privacy of patient information and copies of these policies are available upon request.**
- **I understand that the information collected on this form will be entered into the clinics Practice Management System.**

Sign your name here:______________________ Date:_________

Return this form to the office or teacher before the due date.

Service Provider (Agency):
Phone number:
Address:

Did you fill out the front side of this form?