

Dental Consent Form

First Care Dental Clinic will be doing the all-school free dental inspection pursuant to state **Statute 72-5201** (similar to the vision and hearing inspection) for the Ness City School District. In addition to the free screening we are offering a fluoride varnish treatment. If you would like your child to receive the fluoride varnish treatment please fill out the form below and return to the school. **Thank you!**

Only send the form back **IF** you want the fluoride varnish.

Please check if you would like your child to participate in the application of: Fluoride Varnish

Student Information

Name: _____ **Gender:** Male Female

SSN: _____ **Date of Birth:** _____ **Age:** _____ **Phone #:** _____

Address: _____
 (Street and Apt. or Lot #) (City) (Zipcode)

Student Grade _____ **Teacher Name** _____

Race: Asian American Indian/Alaska Native Black/African American
 Native Hawaiian Other Pacific Caucasian/White More Than One Race

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Which language do you prefer? English Spanish

When did your child last visit the dentist? In the past year More than a year Never

What is the name of the dentist they went to? _____

First Care Dental Clinic will collect payment from KanCare/Medicaid. However, if the services are not covered or your child does not have KanCare/Medicaid, **you will NOT be responsible to pay for any portion of the services.** (Please check all that apply but you need to check at least ONE)

KanCare# _____

NO INSURANCE

Private Dental Insurance (we do not file a claim)

Eligible for free/reduced lunch

Please list any known allergies:

Medical Conditions (check all that apply)

Artificial Heart Valve Heart Murmur Congenital Heart Disorder
 Heart Trouble/Disease Mitral Valve Prolapse Artificial Joint
 Hepatitis Asthma Diabetes Seizure Disorder Autism

Is your child Special Health Care needs? NO YES

Other Medical Conditions/Surgeries/Hospitalizations with dates, if possible: _____

The information from my child's participation in this special event will be utilized anonymously for statistical purposes and information that identifies my child or family will never be disclosed in any form or publication.

First Care Dental Clinic will treat all patient information as protected health information (PHI) under HIPPA regulations, exchanging the PHI only with personnel employed by First Care Dental Clinic, facility/school officials who are responsible for medical/dental treatment and/or record review and their dental or medical providers.

Parent/Guardian Signature _____ **Date** _____