



Working Together for Healthier Kids



Dear Parent/Guardian:

If your student is **not able to have preventive care in a dental office, complete the "YES" box and all the sections below and sign on reverse.** In-school dental treatments include a dental cleaning, brushing instruction, topical fluoride varnish, decay-stopping fluoride, dental sealants and temporary fillings. There is no drilling, no shots and no pain. Sealants are coatings that protect the chewing surfaces of teeth. Decay-stopping fluoride treatments, for back teeth only, help stop a cavity from getting bigger and make it feel better (also called SDF- silver diamine fluoride). You can tell it worked if cavity becomes hard and black over time.

Any child in PreK - grade 12 without access to dental care is welcome to participate.

****If your child DOES NOT visit the dentist routinely, please complete this form ****

Student's Name _____ M F Teacher _____ Grade _____ School _____

YES, I want my child to participate and receive school dental services.

Parent/Guardian _____ Phone _____

Does your child have a dentist? _____ Date of last dental visit? _____ Next visit? _____

****Please complete all information below, provide parent or guardian signature on the back of this form and return to school promptly. Thank you.***

Child's Date of Birth ____/____/____ Address: _____

What is the best way to reach you? _____ Cell phone _____ Email _____

- Does your child have a congenital heart defect requiring pre-medication with antibiotics before dental care? Yes No
- Does your child have any allergies? Yes No If so, explain. _____
- Has your child ever had any serious health problems? Yes No Explain: _____
- Why is your child unable to receive dental treatment in a dental office? **Please check all that apply.**
 Can't find a dentist who accepts child's insurance Cost Transportation Fear
 Can't afford our insurance co-pays Other _____
- Does your child have medical insurance? Yes No Dental insurance? Yes No If so, which kind of dental ins.?
 Name of private insurance: _____
 NH Medicaid – If yes, clearly **write name and Medicaid ID number as they appear on the card:**

Child's Name _____ Medicaid ID number

There is no fee for school dental care. If your child has Medicaid, SCDN will bill Medicaid

***Please provide parent signature and date on back if participating**

Please read, sign and date Informed Consent Below

- **I hereby give permission for the Children’s Dental Network to treat my child during this school year, with dental assessment, cleaning, topical fluoride varnish, dental sealants, decay-stopping fluoride and temporary fillings as needed.** *Not all types of cavities can be treated at school.
- **I understand that** the 2023-24 Salem Children’s Dental Network (CDN) is a program operated by Greater Derry Oral Health Collaborative Corporation (GDOHCC), a 501 (c)(3) non-profit organization independent of the schools in which its programs are delivered.
- **I understand that** any child in PreK – Grade 12 without access to dental care is welcome to participate. A CDN registered dental hygienist certified in public health will provide treatment and an assessment of your child’s teeth. Written results will be sent home to parents and guardians. In some cases, a senior dental hygiene student from NHTI or senior dental student from UNE, under direct supervision by Children’s Dental Network, will provide treatment.
- **I understand that the services provided at school cannot replace regular examination and treatment in a dental office.** Routine care in a dental office is recommended.
- **I understand that** a photograph may be taken of my child’s tooth or teeth only if my child cannot be identified in the picture.
- **I have read the *Notice of Privacy Practices* and I further understand** that Children’s Dental Network may share my child’s dental assessment for treatment and payment activities with the school nurse, the supervising dentist, and in the event of a referral for treatment, with dental offices. **Privacy policy is found at:** www.childrensdentalnetwork.org
- **I understand that** any diagnoses made by dentists who provide this service at school are done on a voluntary basis. No professional fees are charged and no professional reimbursement is received by any volunteer who participates in the school dental program as a service to community children. I understand that all volunteers are provided with limited liability under NH RSA 508:17.

*** Parent/guardian signature**

Date

For dental use only: Examiner _____ Date _____

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31	30	29	28	27	26	25	24	23	22	21	20	19	18	