

SCHOOL - DENTAL OUTREACH PROGRAM 2018-2019 Consent Form



Your child's school has been selected to participate in the Kansas School Sealant Program. Dental Professionals will be offering services in your child's school such as sealants, fluoride varnish, and/or cleanings. **There will be no cost to you or the school for these services. PrairieStar will bill Medicaid or KanCare for services.** If your child has private dental insurance (ex: Delta) it is **NOT** necessary to participate in this program.

HIPAA Privacy Practice & Non-discrimination policies can be located on School or PrairieStar Website.

School or Program Name: _____ Student Grade _____ Teacher: _____

Child's Legal Name: _____ Date of Birth _____ Male Female

check all that apply			
Race/Ethnicity	<input type="checkbox"/> White	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska native
	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other
		<input type="checkbox"/> Native Hawaiian/Pacific Islander	

Parent/Guardian Name: _____

Address: _____ City / Zip _____

Phone _____ Alt. Phone _____

Health History

Does your child have a dentist? Yes No Name of Dentist: _____

When did your child last visit the dentist? 6 months year more than a year never

- | | |
|--|--|
| <input type="checkbox"/> Recent Dental Problems | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Asthma or Wheezing | <input type="checkbox"/> Fainting/Seizures /Epilepsy |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Liver Problems /Hepatitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hemophilia/ Bleeding Problems | <input type="checkbox"/> ANTIBIOTIC NEEDED PRIOR TO TREATMENT |
| <input type="checkbox"/> Heart Problems (Describe) | |

List allergies (including medication)

Other Medical Conditions not listed

Name of Physician and Pharmacy

List Medications child is taking: _____

The state of Kansas and the Dental Professionals administering this program are dedicated to improving your child's oral health by offering outreach dental services. Services may be provided 2X during school year. After your child is treated you will receive a report stating what services were provided along with a dental referral if needed.

The individual's participation in this special event may be utilized anonymously for statistical purposes for the National Institute of Health and Information that identifies you will never be disclosed in any form or publication. You are consenting to a photograph for publicity purposes, which may include print television or web. Consent given voluntarily and without compensation.

FREE

Our services include: Cleaning, Sealants and Fluoride Treatment.

I give PrairieStar Health Center permission to provide preventative dental services for my child and to collect payment from Medicaid or KanCare.

Medicaid # _____ KanCare # _____

Do you have private dental insurance (not Medicaid or KanCare) yes no

Eligible for Free/reduced lunch program

Parent/Guardian Signature _____ Date _____

