A Passion for Excellence

NEENAH Joint School District

FREE

DENTAL SCREENING & FLUORIDE VARNISH APPLICATION

If your preschool, kindergarten and/or elementary school student(s) receive free or reduced cost hot lunch, or have a Forward card from Medicaid (BadgerCare) and DO NOT have dental insurance they are qualified for free dental care.

- Sponsored by Neenah Joint School District.
  Appleton Area School District
  Oshkosh Area School District

- The screening is done by a Registered Dental Hygienist.

- The fluoride varnish is toothpaste like substance, applied by a Hygienist, on all the teeth and is proven to reduce cavities substantially.

If your child qualifies and you would like to participate, please fill out both sides of the attached paperwork and return back to school.

Please complete the attached Consent Form/Medical History and return to your child's school office by September 15, 2015!

If you have any questions PLEASE contact your child's school for additional information.

FOCUS ON THE CHILDREN
A PROGRAM OF TRI-COUNTY DENTAL

See other side for more information

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Joint School District

If your child receives free or reduced cost hot lunch they qualify for this program at No-Charge

Focus on the Children Program Description
(Parent/Guardian Information Sheet)

Phase I Takes place in your child's school.

- Dental health screening
    - Dental hygienist will:
        - Screen and record the student's general oral health.
        - Apply fluoride varnish.

Phase II Takes place at Tri-County Dental Clinic
(A chaperoned school bus will transport children to and from their school to the clinic.)

- A Dental Hygienist will:
    - Clean your child's teeth.
    - Take x-rays.
    - Place sealants if appropriate.
    - Apply fluoride varnish.
- Children participate in a 30 minute oral health educational program.
- A Dentist will do a thorough examination of your child's teeth, preparing a treatment plan if your child requires fillings and/or other dental work.
- Children requiring additional treatment will be scheduled in Phase III.
- Children who are cavity free will be scheduled to repeat Phase II in six month.

Phase III Takes place in the Mobile Dental Clinic or at Tri-County Dental in Appleton.

- A volunteer dentist will provide the necessary dental treatment your child requires.

DENTAL CONSENT FORM

Dear Parent,
On behalf of the Neenah Joint School District, the Tri-County Community Dental Clinic is offering an oral health program for children in your school. The program includes: a dental screening, cleaning, x-rays, fillings and fluoride treatments and oral health education. A new toothbrush, toothpaste, and floss will be brought home.

Please complete this form if you want your child to be part of the program:

***Child's Last Name**:_____ ***First name**: _____

***Child's Date of Birth**:_____-_____-_____ Female / Male Phone Number (_____) _____-_____

Child's Address:_____ County: Calumet/ Outagamie/ Winnebago

Grade in 2015-2016:_____ School: _____

Child's Race/Ethnicity (Check all that apply): _____White _____African American/Black _____Asian
_____Hispanic _____American Indian / Alaska Native _____Native Hawaiian / Pacific Islander _____Other

I understand the nature of the treatment provided and authorize the Tri-County Community Dental Clinic staff to provide oral health treatment.

- I acknowledge that Tri-County Community Dental Clinic may use my child's information for treatment and may disclose it to my insurance company and/or other health care providers even though it may affect future insurance claims.
- I understand that this permission is effective for a period of twelve months in order to provide follow-up services, including restorative treatment, dental cleaning, application of sealants and multiple fluoride applications.
- I understand that my child's restorative treatment plan, if necessary, will be provided to me prior to the treatment starting.
- I am authorizing TCCDC to use nitrous oxide if needed for the completion of dental treatment.
- I agree to the release of my child's treatment plan records so I can receive them from the school.
- That I am specifically authorizing the clinic to treat my child whether or not I am physically present at the clinic during a scheduled treatment.

My signature will confirm my informed consent, my status as the legal custodian of the minor patient identified and my authority to grant this consent. I understand that I may contact Tri-County Community Dental Clinic at 920-882-5500 if I have questions.

_____/_____ Date ____/_____/_____
(Print) parent/guardian **(Signature) parent/guardian**

Does your child see a dentist on a regular basis (every 6 months)? YES / NO
Does your child have allergies to Colophony resin? YES / NO
Does your child have Medicaid (Medical Assistance, BadgerCare, Title 19)? YES / NO
MA Number_____
Does your child have private dental insurance? YES / NO
Name of Dental Insurance Company _____

(OFFICE USE ONLY)

***Verbal permission for Phase 1** ☐ **Signature of School Administrator**_____

For the following medical history questions, please (x) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your child's health. This information is vital to allow us to provide appropriate care for your child. This clinic does not use this information to discriminate.

Medical History

Does your child have or has ever had any of the following conditions:

Yes	No	Unsure		Yes	No	Unsure		Yes	No	Unsure	
☐	☐	☐	Anemia	☐	☐	☐	Herpes	☐	☐	☐	Radiation Treatment
☐	☐	☐	Asthma	☐	☐	☐	High Blood Pressure	☐	☐	☐	Chronic Ear Infections
☐	☐	☐	Autism	☐	☐	☐	HIV/AIDS	☐	☐	☐	Pregnant (at this time)
☐	☐	☐	ADHD/ADD	☐	☐	☐	Hyperactivity				
☐	☐	☐	Birth Defects	☐	☐	☐	Kidney Disease	☐	☐	☐	Sexually Transmitted Diseases
☐	☐	☐	Bleeding Problems	☐	☐	☐	Learning Disabilities				
☐	☐	☐	Blood Disorders	☐	☐	☐	Liver Disease	☐	☐	☐	Hearing Loss/Impairment
☐	☐	☐	Cancer	☐	☐	☐	Mental Disability				
☐	☐	☐	Cerebral Palsy	☐	☐	☐	Muscular Dystrophy	☐	☐	☐	Heart Conditions/Murmur
☐	☐	☐	Developmental Delay	☐	☐	☐	Psychiatric Problems				
☐	☐	☐	Diabetes	☐	☐	☐	Rheumatic Fever	☐	☐	☐	Jaundice (not at birth)
☐	☐	☐	Downs Syndrome	☐	☐	☐	Seizures				
☐	☐	☐	Emotional Problems	☐	☐	☐	Sickle Cell Anemia	☐	☐	☐	Delayed Speech Development
☐	☐	☐	Epilepsy	☐	☐	☐	Skin Disorders	☐	☐	☐	Allergies: _____
☐	☐	☐	Fainting Spells	☐	☐	☐	Tuberculosis				_____
☐	☐	☐	Hepatitis	☐	☐	☐	Tumors				_____

Please explain all "Yes" or "Unsure" responses:

Please list any other problems/conditions your child may have

Current Medications List

Is your child taking any prescription medications, over the counter medications, vitamins, natural and/or herbal dietary supplements? ☐ Yes ☐ No If yes, please list medications.

Medication	Reason for Taking	How Much	How Often

To the best of my knowledge, the indicated health history remains current.
I understand that any change in the patient's health or medication requires that an updated form be completed.
I certify that I have read and understand the above.
I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.
I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____/_____ Date____/____/_____

(Print) parent/guardian (Signature) parent/guardian

Emergency Contact Information:

Name: _____ Relationship: _____

Emergency Number: _____