Madison County Health Department
Oral Health Program
216 Boggs Lane · PO BOX 1208
Richmond, Kentucky 40476-1208
(859) 623-7312

Our **FREE Oral Health Program** is excited to be visiting your child's school this year. The best way to protect children from tooth decay is to stop it before it starts!

The Madison County Health Department Public Health Registered Dental Hygienist (PHRDH) will visually **screen** your child's teeth, provide an age-appropriate **dental cleaning,** and apply **fluoride varnish.**

Every child will benefit from **fluoride varnish,** and it is your child's best friend when it comes to building strong, healthy, beautiful teeth for a lifetime. Under the gums is a little tooth factory that is busy making teeth (baby teeth and permanent/adult teeth). Fluoride begins making teeth strong even before they come in through the gums. It may also prevent, slow down, and reverse the tooth decay process. The varnish is painted on the teeth and may be applied up to six times each year. It is a safe and easy way to help your child stay healthy.

If dental concerns are noted, a referral to the dentist will be sent home for follow up. Your child will receive a toothbrush, toothpaste and dental report card with the visit. This service will be performed **TWICE** each school year (fall and spring semester).

Please complete, sign and return the consent form (on the back of this letter) to enroll your child into the program for this school year.

If you have any question, you may contact Terri Kelly, PHRDH by email at TeresaG.Kelly@madisoncohd.com or (859) 623-7312.

Thank you!

Madison County Health Department Consent for Dental Services PreK-1st Grade

Our **FREE Dental Screening, Age-Appropriate Cleaning and Fluoride Varnish** program will be visiting your child's school during the school day this year. The Madison County Health Department Public Health Registered Dental Hygienist (PHRDH) will screen, clean and apply fluoride varnish **TWICE** each school year (fall and spring semester). The dental visit is a no-out-of-pocket service and families will not be billed for services provided by MCHD.

_☐__ **YES, I DO** consent for my child to receive a dental screening, cleaning and fluoride varnish.

_☐__ **I DO NOT** consent for my child to receive a dental screening, cleaning and fluoride varnish.

(Please Print)

CHILD (first and last name): _____

BIRTHDATE_____ **Parent/Legal Guardian Name** _____

Child's Race _____ **Hispanic or Latino** ☐ Yes or ☐ No **Gender** _____ **# in household** _____

Address _____

Street Address

_____

City/State/Zip Code

Parent/Legal Guardian Phone # _____ **Alternate #** _____

School _____ **Grade** _____ **Teacher**_____

Medical Information/Dental History • Please Provide ALL Requested Information

Does your child have any allergies to latex, foods, PINE NUTS, or medicines (circle one)? Yes or No

If YES, please list:_____

Does your child have ANY illnesses, diseases, or health conditions (circle one) Yes or No

If YES, please list:_____

List ALL medications taken by your child: _____

Child's Dentist (name and phone number) _____

Has your child visited the **SAME** dental office **TWICE in the past two years** for checkups**? Yes or No**

Does your child have private dental insurance? **Yes or No**

Is your child enrolled in Kentucky Medicaid (**circle one**) **Yes or No**

Medicaid ID Number_____ **MCO ID Number**_____

Check MCO: ☐ AETNA ☐ HUMANA ☐ CARESOURCE ☐ PASSPORT ☐ WELLCARE ☐ MOLINA ☐ UHC

CONSENT FOR DENTAL SERVICES: I certify that my answers are correct and completed to the best of my knowledge. Of my own free will, I consent to care for my child which may include dental screening, dental cleaning, fluoride varnish application and any other health service provided by staff or agents of this health department. I understand that no guarantees are being made as to the effect of any preventive service provided for my child. I also understand that x-rays will NOT be taken. I also understand that my child may be tested for HIV, Hepatitis B, or any other bloodborne disease should a health care worker be exposed to blood or bodily fluids. I authorize this health department to release my child's medical/dental information, as permitted by HIPAA, to my child's individual school staff, primary care provider, and dental provider as needed/requested. This program does not replace regular check-ups at a dental office. The services are provided by a PHRDH, and I understand that a dentist is not required to be present for the PHRDH to perform dental procedures (KRS 313.040 Kentucky Dental Practice Act). The PHRDH is working under the supervision of the Madison County Health Department's Board of Health Dentist, Dr. Mary Oldfield. This form, when completed and signed, contains Protected Health Information which will be protected according to HIPAA. My signature acknowledges my understanding of the Madison County Health Department *Notice of Privacy Practices** and how to receive a copy on the date stated. I have read the information, and I understand the items in this packet as they apply to me and my child. My signature below indicates that I do consent, authorize and declare, as stated above. Permission may be revoked at any time. I request that payment of authorized Medicaid benefits be made to MCHD on my child's behalf, for services received and I authorize the release of oral health information about my child to Medicaid to determine payment for services, if applicable.
*You may request a physical copy of our HIPAA FORM or view online by visiting www.madisoncohd.com

X_____

Parent/Legal Guardian Signature and Date (expires one year from date signed) **Date Signed**