

Government of the District of Columbia School Based Oral Health Program Consent Form

Dear Parent or Guardian:

The District of Columbia Department of Health (DC Health) sponsors preventive dental services at your child’s school/facility through the DC School-Based Oral Health Program (SBOHP). Through this program, licensed dentists and their staff provide exams (“checkups”) and x-rays to students who have not seen a dentist in six (6) months. The services include dental cleanings, fluoride treatments, and sealants (as needed). Children who may need additional services such as fillings, drillings, shots, tooth removal, or braces, will be referred to their dental homes. Information from your child’s visit will be shared with the appropriate point of contact at the school/facility, and with the SBOHP for the purposes of follow-up, and program monitoring.

PLEASE NOTE: Children should see their dentists every six (6) months. The SBOHP services should NOT take the place of a visit to a child’s regular dentist. The dental providers will check for dental insurance coverage and the last dental visit for all children to be seen at the school/facility and will bill insurance for any services provided.

CHILD/STUDENT INFORMATION	
Child Name:	
Date of Birth (MM/DD/YY):	Current Gender Identity:
Home Address (Street, City, State, Zip Code):	
School/Facility Name:	Grade:
Teacher Name:	
Parent/Guardian Name:	
Phone Number:	Alternate Phone Number:
Email Address:	
Last Dental Visit: <input type="checkbox"/> 1–3 Months ago <input type="checkbox"/> 4–6 Months ago <input type="checkbox"/> 6+ Months ago <input type="checkbox"/> Unsure <input type="checkbox"/> Never	
Primary Dental Provider:	

HEALTH INSURANCE									
You must select one of the checkboxes and provide all related information in order for your child to receive services.									
<input type="checkbox"/> This child has the following Medicaid/Health Families insurance plan: <input type="checkbox"/> DC Healthy Families <input type="checkbox"/> DC Medicaid <input type="checkbox"/> AmeriHealth Caritas <input type="checkbox"/> MedStar Family Choice <input type="checkbox"/> CareFirst <input type="checkbox"/> Health Services for Children with Special Needs <input type="checkbox"/> Other: _____ <input type="checkbox"/> Medicaid/DC Healthy Families #: _____									
<input type="checkbox"/> This child has private dental insurance: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Insurance Company:</td> <td style="width: 50%; border: none;">Insurance Co. Phone:</td> </tr> <tr> <td style="border: none;">Employer:</td> <td style="border: none;">Employer Phone:</td> </tr> <tr> <td style="border: none;">Name of Insured Adult:</td> <td style="border: none;">Insured Adult’s Date of Birth:</td> </tr> <tr> <td style="border: none;">Member ID/Policy #:</td> <td style="border: none;">Group #:</td> </tr> </table>		Insurance Company:	Insurance Co. Phone:	Employer:	Employer Phone:	Name of Insured Adult:	Insured Adult’s Date of Birth:	Member ID/Policy #:	Group #:
Insurance Company:	Insurance Co. Phone:								
Employer:	Employer Phone:								
Name of Insured Adult:	Insured Adult’s Date of Birth:								
Member ID/Policy #:	Group #:								
<input type="checkbox"/> This child does not have any dental insurance									

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As the parent/guardian of the above-named student, I consent for him/her to receive dental services through the DC Health School-Based Oral Health Program. I understand that my child’s participation provides consent for the following:

- The dental provider to verify insurance before services are provided.
- The dental provider to bill & collect payment from any Medicaid, private insurance, or other payer.
- If I have private dental insurance, the dental provider to bill the family for any deductibles and/or copays.
- The dental provider to confidentially share my child’s clinical information with DC Health, DC Department of Health Care Finance, Medicaid Managed Care Organizations, and/or other clinical providers involved in my child’s health care.

Further, I agree to discharge, indemnify, and hold harmless the Government of the District of Columbia and any agency, employee, officer, agent or representatives thereof from all claims, demands, actions, or judgments which I or my heirs, executors, administrators, or designees may have for any and all injuries and damages, known or unknown, caused by or arising from the activities listed above. **I understand that if I fail to sign this consent form, my child will not receive any services offered under this program.**

I understand I may revoke this consent at any time by providing written notice to DC Health’s Oral Health Program (899 N. Capitol St. NE, 3rd Floor, Washington, DC 20002) or via email hcab.dchealth@dc.gov. I further understand that until this revocation is made, the consent for services shall remain in effect for one calendar year from the date it is signed, and my child’s information will continue to be accessible by the parties listed above for the specific purposes described.

Please provide the following information to help the dental provider best serve your child:

MEDICAL INFORMATION
Check each condition that applies to your child and explain in the space provided
<input type="checkbox"/> Dental problems
<input type="checkbox"/> Heart problems/valve replacements/shunts
<input type="checkbox"/> Asthma/breathing problems
<input type="checkbox"/> Epilepsy/seizures
<input type="checkbox"/> Allergies <input type="checkbox"/> Latex allergy <input type="checkbox"/> Pine nut allergy <input type="checkbox"/> Acrylic allergy <input type="checkbox"/> Other
<input type="checkbox"/> Current medications
<input type="checkbox"/> Antibiotics premedication required
<input type="checkbox"/> Other health problems (diabetes, bleeding problems, communicable diseases, etc.)
Child’s Primary Care Doctor and/or Provider (if applicable):

I have read the notice on the back of this page and understand and agree to its terms. By signing, I give my informed consent for my child to receive services through the DC Health School-Based Oral Health Program.

Parent/Guardian Signature: _____ **Date:** _____