# Barren River
## DISTRICT HEALTH DEPARTMENT
Barren, Butler, Edmonson, Hart, Logan,
Metcalfe, Simpson, and Warren Counties

CONSENT FOR DENTAL TREATMENT

**SCHOOL NAME_____ HOMEROOM TEACHER_____**

CHILD'S NAME _____ BIRTHDATE: _____ RACE: _____ HISPANIC ☐Y ☐N

ADDRESS: _____ ☐MALE ☐FEMALE

SCHOOL THIS CHILD ATTENDED LAST YEAR_____

**CHILD'S** SOCIAL SECURITY #:_____ HOME PHONE #:_____ WORK/CELL#:_____

EMERGENCY CONTACT NAME: _____ PHONE#_____
Who does the child live with? _____

**KY MEDICAID # (if applicable**):_____
STUDENT'S DOCTOR: _____ DOCTOR'S PHONE #:_____
STUDENT'S DENTIST: _____

WHEN WAS HIS/HER LAST DENTAL CHECK-UP? _____ DOES YOUR CHILD REGULARLY SEE A DENTIST? _____

Has your child ever had any of the following?
☐ Any Operations
☐ Bleeding Problems
☐ Convulsions / Epilepsy
☐ Diabetes
☐ Hearing Impairment
☐ Heart Murmur
☐ Heart Problem of Any Kind
☐ Hemophilia
☐ HIV+ / AIDS
☐ Hyperactive
☐ Rheumatic Fever / Scarlet Fever
Other _____

***DOES YOUR CHILD REQUIRE PRE-MEDICATION (antibiotics)?*** ***Please circle YES*** ***NO***

***Please circle one if applicable: Pregnant Taking oral contraceptives***

**ALLERGIES/ASTHMA** (food, insects, medication, other) _____
**CURRENT MEDICATIONS:** _____

**CONSENT FOR HEALTH SERVICES AND ASSIGNMENT OF BENEFITS** (Expires 1 year from date signed)

I certify that my answers are correct and complete to the best of my knowledge. Of my own free will, I consent to care which may include dental assessments/exams, dental cleanings, x-rays, fluoride treatments, amalgam(silver)and/or composite(white) fillings, minor extractions(tooth or teeth pulled) and dental sealants by a Dentist and/or a Public Health Registered Dental Hygienist affiliated with the Barren River District Health Department. The dentist will be present to perform the exam, fillings, and extractions but May or may not be present during the cleaning, fluoride, x-rays and sealant appointment. If your child has cavities or needs an extraction of a tooth, they may be referred out to a participating dentist with BRDHD. I understand that no guarantees are being made as to the effect of any exam or treatment on my child. I understand that my child may be tested for HIV infection, Hepatitis B, or other diseases carried by the blood or body fluids if such tests are needed only in the event that a healthcare worker is exposed to his/her blood, body fluids or tissue. I authorize the dental clinic to release dental information about my child, as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to his/her primary care provider and to share pertinent dental information (history of allergies or significant dental history) with school staff who may need to provide care to my child in an emergency. I understand that the sharing of this information is on a need to know basis only. I request that payment of authorized medical insurance benefits be made to Barren River District Health Department on my behalf, for services my child receives. I also authorize the local health department to release dental information about my child to Medicaid/KCHIP to determine payment for services. I also understand by signing this consent, I acknowledge that I have received a copy of the Barren River District Health Department's Privacy Notice. I have read the above and I understand the items above as they apply to me. Signature below indicates I do consent, authorize and declare as stated above. This permission can be revoked at any time.

_____ _____ _____
(Signature of Parent/Guardian) (Printed Name of Parent/Guardian) (Date Signed)