

Salud Family Health Centers SMILES Fort Morgan High School Consent Permission Form

Fort Morgan High School and Salud Family Health Centers will be providing preventative dental services throughout the school year. **All children are eligible** to receive these dental services regardless of their dental insurance/Medicaid. If the child has Medicaid, CHP+, or Delta Dental insurance Salud will bill these programs for services provided. Salud is waiving the copays for these services due to the burden of collecting copays from children in a school setting. **Families will not be billed for these services.** As a health center, we are required to ask about income levels. All information is confidential. Children will have their teeth and gums checked for potential problems and parents will be informed if a child has any cavities or needs further treatment by a dentist.

When electing to participate in this program, your child will be seen at his/her school by a Registered Dental Hygienist. The dental hygienist may provide some or all of the services listed below and communicate with a dentist through a computer about your child's teeth and gums. The dentist will review the information gathered by the dental hygienist (x-rays, dental history, photos, etc.) and will develop a recommended treatment plan.

I give permission for the dental hygienist to provide some or all of the following services for my child:* Yes No

**Due to COVID-19 outbreak, some services listed below will be postponed until 2021*

- Complete Dental Exam
- X-rays
- Teeth Cleaning
- Pictures of his/her teeth
- Fluoride treatment
- Sealants

Does your child have allergies or any medical conditions? Yes No

Please explain if answered Yes: _____

If your child needs extensive treatment that can only be done at a dental office, your child will need to be seen at the Salud Family Health Centers clinic or by your regular family/pediatric dentist.

A copy of Salud's Notice of Privacy Practices is attached hereto and can be found at <http://www.saludclinic.org/>. This document informs patients about how their protected health information will be shared or kept confidential. I certify that I have read (or had read to me) the contents of this form and that I have access to Salud's Notice of Privacy Practices. I understand that if I need further information or if I have any questions that I can contact **SMILES Project Navigator at 970-441-6049**. I understand that my child's screening results may be shared with their school's health assistant/health paraprofessional. I believe that I have been given sufficient information to give my consent.

Parent/Guardian Signature: _____ Date: _____

School: _____ Grade: _____ Teacher: _____

"Salud is a federally qualified health center whose mission is to provide a quality, integrated health care home to the communities we serve. As part of our federal grant requirements, we need to collect all of the information below."

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| Child's Last Name: | Child's First Name: | Email Address: |
| Date of Birth: | Age: | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Parent/Guardian Name: | Parent/Guardian DOB*Relationship to Patient: | Home Phone: |
| Address: | City, State, Zip: | Cell Phone: |
| Household size: _____ Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Latino Race: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian <input type="checkbox"/> Other | Total Estimated Income: _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual Does your family live in public housing? <input type="checkbox"/> Yes <input type="checkbox"/> No Is your family currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No Is anyone in your family a migrant or seasonal farmworker? <input type="checkbox"/> Yes <input type="checkbox"/> No Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ | |
| Type of dental insurance? Subscriber number : | <input type="checkbox"/> CHP+ <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> None | |
| Has your child seen a dentist before: <input type="checkbox"/> No <input type="checkbox"/> Yes - date of last apt _____ with DR. _____ | | |