

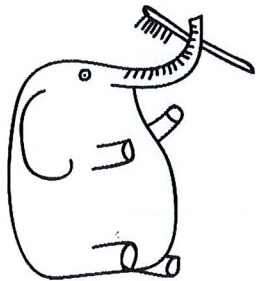
Children's
Clinic

Oak Park River Forest
Infant Welfare Society

In-School Dental Clinic

Dental Screening Program

We are offering dental screenings in partnership with the IWS Children's Clinic. Havlicek Elementary was chosen to take part in this project, which provides dental exams at school. **All children are eligible to participate regardless of insurance status!**



Children in kindergarten, second, sixth, and ninth grades are required to receive a dental exam. Signing your child up for this program will fulfil this requirement. You will receive a copy of your child's dental exam after he/she is seen.

Eligible children covered by Medicaid will also receive a dental cleaning and fluoride varnish if it has been 6 months or more since their last cleaning/fluoride. Based on dentist's recommendation, Medicaid children will also qualify for sealant placement.

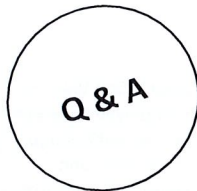
If you wish for your child to participate, please take a moment to read this letter, complete the **consent form** on the back of this sheet and return it to your child's teacher or school nurse.

Permission Form Due:

January 7th

Screening Date:

January 13th -15th



Q: What students are eligible to participate in this program?

A: ALL students are eligible.

Q: What is a dental exam?

A: A dental exam evaluates an individual's oral health and hygiene. The dentist checks the teeth and gums for any abnormalities and will make recommendations for further treatment as needed.

Q: Does this program check insurance eligibility?

A: Yes. This allows us to determine which students are eligible for a cleaning, fluoride, and sealants.

Q: Will families be billed for this service?

A: Families will not be billed directly; however, we do bill through Medicaid since 100% of preventative services are covered through insurance plans.

Q: What are dental sealants?

A: Dental sealants are thin plastic coatings that are applied to chewing surfaces to help prevent cavities. Sealants painted on the back teeth and harden to form a protective shield.

Q: Does this program treat cavities on site?

A: No. If a student has restorative needs (cavity, abscess, inflamed gums, etc.), we will make a referral for an in-office dental appointment for further treatment.



Please contact **Audrey Greffin** at (708) 848-0528 with questions. This program does not replace the advice or care from your regular dental professional. If your child does not have a dentist, please contact the **IWS Children's Clinic** at (708) 848-0528 to schedule an appointment. Thank you.

IWS Children's Clinic, 28 Madison Street, Oak Park, Illinois 60302

telephone 708.848.0528 fax 708.848.5855 email info@childrensclinicIWS.org web www.childrensclinicIWS.org



Children's
Clinic
Oak Park River Forest
Infant Welfare Society

Dental Treatment Agreement and Parent/Guardian Release of Liability Consent Form

Child's First Name _____

Child's Last Name _____

Child's Age _____

Date of Birth _____

Child's Race/Ethnicity _____

Sex _____

Female or Male or Other

Parent/Guardian's Name _____

Telephone Number _____

Teacher's Name _____

Address _____

School _____

City, State, Zip _____

Is your child eligible for the Free or
Reduced Lunch Program? YES NO

Grade _____

Is your child enrolled in **Medicaid**?
(All Kids Program/public aid) YES NO

Is your child covered by **private insurance**?
YES NO

If yes, include your child's recipient ID number:

ID# _____

Release of Liability for the Dental Program. I give my consent for the IWS Children's Clinic sponsored by the Oak Park River Forest Infant Welfare Society, to provide dental care to my child. I hereby release, waive and discharge the **IWS Children's Clinic and Havlicek** their employees and agents, from any liability to me, my personal representatives or next of kin for any and all damages, and any claim or demands made on account of injury or dental disease resulting from the dental procedures. I have read and understood this agreement and voluntarily agree to all of its terms and conditions. I understand that the IWS Children's Clinic is providing these procedures as a public service. This authorization expires five years from this date. This will also grant permission for IDPH Quality Assurance Audits to be performed and providers to return to your school to recheck your child's sealants within 365 days from the date of service. This Dental Health Services Program was provided by the IWS Children's Clinic. Dentists and dental hygienists will come to your child's school with portable equipment to perform these services. In order for your child to fully participate, you **MUST** complete this form, SIGN below, and RETURN to your child's school. **Do not return this form if you are not interested in this service.**



Signature of Parent/Guardian: _____

Date: _____

Health History

Mark if your child has had any of the following:

- Heart Disease
- Diabetes
- Epilepsy or Seizures
- Blood Diseases or Disorders
- Asthma
- Latex Allergy
- Allergies

If yes, List Allergies: _____

Date of Last Dental Exam and Dental Cleaning _____

Name of Family Dentist _____

Is your child taking any medications? YES NO
If yes, List Medications: _____

Has your child had injuries to mouth, head or teeth?
YES NO