HEALTH RESOURCE CENTER SERVICES
BROOKLYN CENTER MIDDLE & HIGH SCHOOL

The Health Resource Center, located at Brooklyn Center Middle and High School STEAM School, provides free and low cost health services for Brooklyn Center students (some services are available for community members as well). Many services are also provided on-site at the Brooklyn Center Early College Academy.

MENTAL HEALTH SERVICES
- FREE AND LOW COST for insured and uninsured students
- Available for BCCS students

MEDICAL SERVICES
- FREE AND LOW COST for insured and uninsured students
- Brooklyn Center residents ages 0-19 and Brooklyn Center Students
- Walk-in services at Brooklyn Center STEAM (BCS) Tuesdays/Thursdays 1-5pm during the school-year
- Walk-in services at the Early College Academy (ECA) Tuesdays 11:30-1pm during the school-year (ECA and Centaur Beginnings students only)
- Please note: During school breaks, hours may change. Call the clinic to schedule an appointment.

DENTAL SERVICES
- FREE AND LOW COST for insured and uninsured students

EYE EXAMS AND GLASSES
- FREE AND LOW COST for insured and uninsured students

SEXUAL HEALTH SERVICES AND EDUCATION
- FREE AND LOW COST for insured and uninsured students

ASSISTANCE WITH HEALTH INSURANCE APPLICATIONS
- FREE Referrals

SEXUAL VIOLENCE AND RELATIONSHIP SUPPORT SERVICES
- FREE AND LOW COST for insured and uninsured students

CHEMICAL HEALTH SCREENINGS
- FREE
- Available for BCCS Students Includes assistance with questions/concerns about alcohol or drug use

Located in Brooklyn Center Middle & High School
6500 Humboldt Ave. N., Brooklyn Center, MN
For an appointment, call 763-314-8374.

BROOKLYN CENTER COMMUNITY SCHOOLS
HEALTH RESOURCE CENTER

School Year _____

BROOKLYN CENTER HEALTH RESOURCE CENTER
CONSENT FOR MEDICAL CARE

Children and youth, from birth through high school graduation, who live, work or go to school in the Brooklyn Center School District, are eligible to receive free medical care at Brooklyn Center Health Resource Center. For them to receive the medical services listed below, you must complete this consent form and return it to Brooklyn Center Health Resource Center.

I give permission for my child to use the medical services at Brooklyn Center Health Resource Center.

Child's Name: _____ Date of Birth: _____

I will allow my child to receive **ALL*** medical clinic services, including the following:

- **Routine care:** Treatment for minor conditions such as colds, flu, infections, headaches, earaches, sore throats, sprains, cuts, burns, skin problems, stomach pain and back pain; physical exams for sports; vision & hearing screenings; and immunizations
- **Health education:** Weight management, special diet counseling, smoking prevention, and safety promotion
- **Lab services:** Routine blood and urine tests, throat cultures, and diabetes tests
- **Counseling:** Help dealing with stress, anxiety, depression, abuse and neglect, mental health, self-esteem development, and suicide prevention

*** IMPORTANT: If there are services listed above you do not want your child to receive, please cross them out. He or she will receive only those services that remain on the list. Please be aware that Minnesota Law does allow your child to receive treatment, without your permission or consent, for sexually transmitted infections, chemical dependency, and pregnancy and conditions associated with pregnancy, including pregnancy prevention.**

Allergies

My child has the following allergies:_____

Medications

My child uses the following medications:_____ _____

Do you have medical insurance? YES _____ NO _____

We ask for this information only to coordinate with the Minnesota Vaccine for Children program. Medical visits to Brooklyn Center Health Resource Center are free and your insurance will not be charged.

Signature: _____ Date: _____
(Parent or Guardian)

Relationship to student: _____ Daytime phone: _____

This consent form will be on file at the clinic and is valid for one academic year. A written consent is required annually.

Please return signed form to _____

School Year _____

Park Nicollet
HealthPartners

BROOKLYN CENTER HEALTH RESOURCE CENTER
CONSENT TO SHARE LIMITED INFORMATION 18+

I give permission for Brooklyn Center Health Resource Center to provide limited information about me to employees of Brooklyn Center School District who are involved in health center operations.

I understand that a school employee provides some administrative services to Brooklyn Center Health Resource Center. These services may include things like helping make appointments, getting signatures on forms, and helping communicate with the school nurse if the school nurse is also involved in my health care. The school employee will keep all information he or she obtains about me confidential and will not share it with others at the school, except as needed to coordinate my care.

Name _____ Date of birth _____

Signature _____ Date _____

This permission is valid for one year from the date of signature unless I revoke it.

Please return signed form to _____

Revised Nov 2018

Children's Dental Services

636 BROADWAY ST NE, MINNEAPOLIS, MN 55413
TEL: (612) 746-1530 FAX: (612) 746-1531

Authorization for Dental Exam and Treatment at School

Children's Dental Services(CDS) providesdental care atschool, includingexams, x-rays, cleanings, fluoride, sealants, fillings, crowns, primary tooth extraction, silver diamine fluoride (SDF), and others, as needed, during regular school hours. **If you would like your child to receive dental care, please fill out this form and return it to the school nurse. This consent will be valid for 1 year from the date signed.**

Onlycompletethis form if you would like your child to be seen exclusively by dental providers from CDS.

Child Information

Name: _____ **Date of Birth:** ____/____/____
First Middle Last Name(s) mm dd yyyy

Sex: ☐ Male ☐ Female **Pronouns:** _____ **Primary/Home Language:** _____

School: _____ **Grade:** _____

Guardian Information

Name: _____ **Date of Birth:** ____/____/____
First Middle Last Name(s) mm dd yyyy

Address: _____
Number Street Apt/Unit City State Zip Code

PhoneNumbers : (_____) _____ - _____ (_____) _____ - _____

E-mail: _____@_____

Patient Medical History

1. **Hasyourchildbeen seen atanotherdentist in thelast 6months?** ☐ No ☐ Yes, where? _____
   Approximate date of last visit: ____/____/____ & x-rays: ____/____/____
   mm dd yyyy mm dd yyyy
2. **Isyour childhaving anydental-related pain orconcerns?** ☐ No ☐ Yes, explain: _____
3. **Indicate if any of the following apply to the patient by marking each box:**

Attention DeficitHyperactivity Disorder(ADHD)	☐Yes ☐No	Chemical Dependency	☐Yes ☐No	Hemophilia	☐Yes ☐No
Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)	☐Yes ☐No	Cold Sores/Blisters	☐Yes ☐No	Hepatitis/Liver Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Congenital Heart Disease	☐Yes ☐No	High Blood Pressure	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Dental Anxiety	☐Yes ☐No	Kidney Disease	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Developmental Disability	☐Yes ☐No	Radiation/Chemotherapy	☐Yes ☐No
Arthritis	☐Yes ☐No	Depression / Anxiety	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Asthma / Wheezing	☐Yes ☐No	Diabetes	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Autism Spectrum Disorder (ASD)	☐Yes ☐No	Acid Reflux (GERD)	☐Yes ☐No	Tuberculosis**	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Epilepsy / Seizures	☐Yes ☐No	Skin Issues/Eczema/Rash	☐Yes ☐No
Cancer	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Sexually Transmitted Infection (STI)	☐Yes ☐No
Current Pregnancy ☐ No ☐ Yes, due date : ____/____/____	☐Yes ☐No				☐Yes ☐No
				Other: _____	

****If you responded yes to tuberculosis, have they had a recent positivetestresultand/oraretheycurrentlyintreatment?Hasaphysician indicated that the tuberculosis is dormant or not currently active?** _____

4. **Do they have any allergies?** ☐ No allergies ☐ Silver ☐ Latex ☐ Dye ☐ Food: _____
   ☐ Drugs: _____ ☐ Other: _____ **Explain:** _____
5. **Are they taking medications, drugs, vitamins, or herbal supplements?** ☐ No ☐ Yes, list which: _____
6. **Have they had an unusual reaction to dental anesthetic?** ☐ No ☐ Yes, explain what the reaction was: _____
7. **Have they had any excessive bleeding that needed special treatment?** ☐ No ☐ Yes

Continue to next page →

8. **Have they seen a physician or been hospitalized within the past two years?** ☐ No ☐ Physician ☐ Hospitalization

Reason: _____

9. **Have they had any surgery or operation?** ☐ No ☐ Yes, explain the reason: _____

_____. If you had any complications, which? _____

Dental Insurance Information (Response Required)

- **Ourservicesarebilleddirectlytoyourchild's dentalinsurance,socompleteinsuranceinformationisneededtosee them.** Please, answer the following questions fully:

☐ Minnesota State Covered Insurance (MA) **PMI orMedicaidID #:** 0 _____

☐ Private Insurance. Fill out the following information for the **subscriber**:

Insurance Company Name: _____ Customer Service Number: (_____) _____ - _____

Employer: _____ Employee Name: _____
First MI Last Name(s)

Date of Birth: ____/____/_____ Member ID #: _____ Group #: _____
mm dd yyyy

- If your child does not have insurance, CDS can help you apply for MN state insurance or offer a reduced cost to families who are income-eligible. If no insurance, indicate your interest: ☐ Help applying to state insurance ☐ Discount with CDS

Acknowledgment

Igive permission for CDS to provide a dental exam, preventive services and required restorative dental treatment. Specifically, I consent to routine dental treatments being performed on my child, including examinations, x-rays, cleanings, fluoride, silver diamine fluoride (SDF), and plastic sealants. I understand that CDS staff will contact me for additional informed consent to provide restorative procedures, such as fillings, crowns, extractions of primary teeth, dental anesthetic, and other treatments as needed, and it is my responsibility to provide correct contact information.

I understand that there are risks associated with any procedure but that these risks are often outweighed by the benefits of such treatment. Risks of **not** having treatment done include the following:

- Toothache,infection, and/or abscesscausingpain, fever, and swelling, with the possibility of infection spreading to other parts of the body and leading to potentially life-threatening complications
- Difficulty chewing and/or maintaining good nutrition
- Gum inflammation
- Developmentof cystin gumtissue
- Facial swelling
- Tooth sensitivity to hot or cold
- Ongoing pain, bad breath, unpleasant taste in mouth, and difficulty opening mouth
- Loss of teeth

I also understand that, while rare, there are certain inherent and potential risks in any treatment plan or procedure, and that such operative risks include but are not limited to the following:

- Occasional bleeding ofthe gums thatcan last up to 12 hours
- Swelling of the face, pain, or jaw stiffness that can last for several days
- Injury to adjacent teeth, tissue or fillings
- Fracture of the jaw and the necessity to surgically treat the fracture
- Unexpected reaction to dental anesthetic
- Injury tothe nerve underlying the lower teeth, resulting in numbness, tingling, pain, or other sensory disturbances to the lips, cheek, chin, gums, teeth and tongue
- Infection of the tooth socket of an extracted permanent tooth, resulting in pain, tenderness, or swelling
- Biting of the lip while anesthetic effect is still present

By signing this consent form, I give permission for CDS to bill my insurance for any services provided to the individual listed for care, and I understand that I am responsible for any amount not covered by the insurance. To provide the most comprehensive care possible, I give permission for CDS to share the patient's oral health information with the school. **This consent is valid for 1 year from the date signed unless revoked in writing to CDS.** If I had any further questions about the risks and benefits of treatment or alternate treatment options, I contacted a provider at CDS to ask such questions, and they were answered adequately. I have had adequate time to make the decision to give consent freely. The medical history provided is accurate to the best of my knowledge, and if this changes, I will inform CDS.

Signature of Parent/Legal Guardian (or 18+ year-old student) _____ **Date (Valid for one year)**