HEALTH RESOURCE CENTER SERVICES
BROOKLYN CENTER ELEMENTARY SCHOOL

The Health Resource Center, located at Brooklyn Center Elementary STEAM School, provides free and low cost health services for Brooklyn Center students (some services are available for community members as well).

MENTAL HEALTH SERVICES

- FREE AND LOW COST for insured and insured students
- Available for BCCS students

MEDICAL SERVICES

- FREE AND LOW COST for insured and insured students
- Brooklyn Center residents ages 0-19 and Brooklyn Center Students
- Walk-in services and appointments at Brooklyn Center Elementary Mondays and Wednesdays from 1-5pm during the school-year
- 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

ASSISTANCE WITH HEALTH INSURANCE APPLICATIONS

- FREE Referrals

STUDENTS MUST TO BE ACCOMPANIED BY A PARENT OR GUARDIAN DURING THEIR VISIT TO THE BCE CLINIC.

Located in Brooklyn Center Elementary
1500 59th Ave. N, Brooklyn Center, MN 55430
For an appointment, call 763-314-8374.

BROOKLYN CENTER COMMUNITY SCHOOLS
HEALTH RESOURCE CENTER

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

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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)**

ODAM MEDICAL GROUP
Family Care & Chronic Diseases

Consent to Treat Form

1. I _____(parent name) give permission for **Odam Medical Group** to give _____ (child's name) medical treatment which may also include all due vaccinations.
2. I allow **Odam Medical Group** to file for insurance benefits to pay for the care I receive
   - I understand that:
   - **Odam Medical Group** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs
   - I must pay for the cost of these services if my insurance does not pay
   - If you do not have insurance, you will not be billed.
3. I understand
   - I have a right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician
4. I give permission for **Odam Medical Group** to provide limited information about my care to Brooklyn Center Community Schools staff who are involved in health center operations, school nurse if the nurse is also involved in my child's health, other staff if applicable. Health information will remain confidential and protected with HIPPA and FERPA.

PLEASE COMPLETE THE FOLLOWING

First Name _____ Middle Name_____ Last Name_____

Date of Birth _____ Phone Number_____Gender _____

Ethnicity_____ Race_____

Address_____
City_____ State _____ Zip Code _____

Insurance_____**Group Number**_____ **ID Number**_____

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date
(For children under 18

_____
Parent or Guardian Print Name