

# 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 uninsured 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

### Authorization for Dental Exam and Treatment at School

Children's Dental Services(CDS) provides dental care at school, including exams, 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.**

Only complete this 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

**Phone Numbers :** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**E-mail:** \_\_\_\_\_@\_\_\_\_\_

#### Patient Medical History

1. **Has your child been seen at another dentist in the last 6 months?**  No  Yes, where? \_\_\_\_\_  
 Approximate date of last visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ & x-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy mm dd yyyy

2. **Is your child having any dental-related pain or concerns?**  No  Yes, explain: \_\_\_\_\_

3. **Indicate if any of the following apply to the patient by marking each box:**

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

**\*\*If you responded yes to tuberculosis, have they had a recent positive test result and/or are they currently in treatment? Has a physician 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

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)

- Our services are billed directly to your child's dental insurance, so complete insurance information is needed to see them. Please, answer the following questions fully:
  - Minnesota State Covered Insurance (MA) PMI or Medicaid ID #:
  - Private Insurance. Fill out the following information for the **subscriber**:  
Insurance Company Name: \_\_\_\_\_ Customer Service Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Employee Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
mm dd yyyy First MI Last Name(s)
- 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

I give 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 abscess causing pain, 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
- Development of cystin gum tissue
- 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 of the gums that can 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 to the 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)



## 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  
(For children under 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Print Name