

To: Parents of Oregon Community School District #220

From: Sharon Hoover, RN CSN

Date: February 14, 2017

Re: School-Based Dental Program

Dear Parents,

The Whiteside County Health Department will be offering a dental clinic to all students again this year. The dentist will be here at the school on March 1st and 2nd. If you would like your child to participate in this clinic, please complete and return the permission form. You can print form @ www.ocusd.net or pick up in any of the school offices.

Dental exams are required for students entering Kindergarten, 2nd and 6th grades. For those students that have not fulfilled this requirement, this would be an excellent opportunity to do so.

Please have permission slips returned to school nurse by February 22nd.

Sincerely,

Sharon Hoover, RN CSN



WCHD School Dental Clinic Program
 Permission Form
 2016-2017

1300 W. 2nd St.
 Rock Falls, IL 61071
 (815) 626-2230

If you would like your child to participate in the school dental clinic, please complete this form and return to your school nurse.

A quality public health dental clinic is coming to school! Our school exam fulfills the state law requiring all K, 2nd, and 6th graders to have a mandatory dental exam. This program prevents tooth decay by providing exams, cleanings, fluoride and sealants (a protective coating on the chewing surfaces of the back teeth) to children in need of dental care. A referral may be made to the Whiteside County Community Health Clinic in Rock Falls for follow-up dental care, if needed. A discounted fee of \$40 may be available, depending on income (see chart on back). Medicaid/All Kids, insurance and private pay is accepted. **All insurance information must be completed or full-fee will be charged. Any balance unpaid by insurance will be charged to the parent/guardian.** Thank you for helping us to promote oral health for children.

PLEASE CIRCLE OR WRITE-IN THE APPROPRIATE ANSWER:

Child's Name:		Grade:	Teacher:	Birthdate: / /				
Address:			City:	Zip:	Male or Female			
County:	Phone:	Emergency Contact (Relationship):		Phone:				
Ethnicity:	Hispanic	Non-Hispanic	Race:	White	African American	Native American	Asian/Pacific Islander	Other: _____
When was your child's last dental visit?			Dentist:	For what service?				

MEDICAL INFORMATION:

Has child complained of dental problems?	YES	NO	If YES, what?			
List all known allergies:						
Has your child ever had any of the following? If YES, please circle:	Currently has Heart Murmur	Latex Allergy	Diabetes	Asthma		
Seizures	Hepatitis	Anemia	Bleeding Disorders	Cancer	Thyroid	Rheumatic Fever or Rheumatic Heart Disease
Other medical conditions (please list):						
Is your child taking any medications? If YES, please list:						

PAYMENT INFORMATION: (please mark payer source and complete chart on back, if applicable)

- **ALL insurance information must be completed or full-fee will be charged.**
- **ANY BALANCE UNPAID BY INSURANCE WILL BE CHARGED TO THE PARENT/GUARDIAN.**

No Dental Insurance or ILLINOIS Medicaid / All Kids: (see chart on back for discounted fee eligibility)		
ILLINOIS Medicaid / All Kids: Provide Child ID #:		
Private Dental Insurance:		
Insured's Name:	Insured's Birthdate: / /	Insured's SSN or ID#:
Insured's Address:		
Insured's Phone:	Insured's Employer:	
Dental Insurance Company:	Address:	Group#: Phone:

PARENT OR GUARDIAN MUST SIGN FOR CHILD TO PARTICIPATE

I am a custodial parent or legal guardian of the child named below. I give permission for my child to receive dental treatment, and allow the school nurse/school representative and dental provider access to my child's dental record. I also acknowledge that I have reviewed and received the Summary of Notice of Privacy Practices on the back of this form. I understand that I may ask for a copy of the full notice. To ensure program quality, my signature also gives permission for the Illinois Department of Public Health to review this record and to have WCHD return to school at a later date to check the retention of my child's sealants and replace if missing.

Parent/Guardian Signature: _____ Date: _____

SEE OTHER SIDE for INCOME GUIDELINES

Using the Free and Reduced Lunch income guidelines below,
CIRCLE YOUR HOUSEHOLD SIZE AND MONTHLY GROSS INCOME RANGE:

If you do not have insurance,
CIRCLE THE MONTHLY INCOME
 based on your family size
 to see if eligible for a grant for dental care.
 If "**NOT ELIGIBLE**" for Free or Reduced
 Lunch, your child may be seen by the dentist
 for a **\$40.00** fee.
**PAYMENT IS EXPECTED AT THE
 TIME OF SERVICE.**
*You must circle the income section for a grant
 consideration.*

Household Size	Free (130% FPL)	Reduced (185% FPL)	NOT ELIGIBLE
1	\$1,287 or under	\$1,288 - \$1,832	\$1,833 or greater
2	\$1,736 or under	\$1,737 - \$2,470	\$2,471 or greater
3	\$2,184 or under	\$2,185 - \$3,106	\$3,107 or greater
4	\$2,633 or under	\$2,634 - \$3,747	\$3,748 or greater
5	\$3,081 or under	\$3,082 - \$4,385	\$4,386 or greater
6	\$3,530 or under	\$3,531 - \$5,023	\$5,024 or greater
7	\$3,980 or under	\$3,981 - \$5,663	\$5,664 or greater
8	\$4,430 or under	\$4,431 - \$6,304	\$6,305 or greater
Each additional household member	Add \$451	Add \$642	Add \$642

**WHITESIDE COUNTY HEALTH DEPARTMENT & COMMUNITY HEALTH CLINIC
 SUMMARY OF NOTICE OF PRIVACY PRACTICES**

This notice describes how health information about you may be used and disclosed and
 How you can get access to this information. *Please review it carefully.*

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims record
- Correct your health & claims record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you as your personal representative
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we may share your information:

- Disclosing information to your family and friends (requires written authorization)
- Tell family and friends about your condition
- Provide disaster relief
- Market our services and sell your information (requires written authorization)
- Raise funds

OUR USES AND DISCLOSURES

We may use & share your information as we:

- Treat you
- Run our organization
- Bill for your health services
- Help with public health and safety issues
- Do research
- Comply with the law, such as providing proof of immunity to a school
- Respond to organ & tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Provide you with appointment reminders such as voicemail messages, postcards, texts or letters

We will never share any health information regarding Behavioral or Mental Health Services, Substance Abuse (drug/alcohol) Treatment, Physical Assault/Abuse/Neglect, and/or Sexually Transmitted Diseases Including HIV/AIDS.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.
 We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
 We must follow the duties and privacy practices described in this notice and give you a copy of it.
 We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.