



# Siskiyou Community Health Center

## STUDENT HEALTH CENTER

### LORNA BYRNE MIDDLE SCHOOL

101 South Junction Avenue  
Cave Junction, OR 97523  
Main Office: (541) 592-6978  
Fax: (541) 592-6702

**ALL STUDENTS WHO PLAN TO USE THE LORNA BYRNE MIDDLE SCHOOL STUDENT HEALTH CENTER FOR THE 2018/2019 SCHOOL YEAR MUST COMPLETE AND RETURN THE LBMS HEALTH CENTER PACKET.**

#### **What is a School-Based Student Health Center?**

A School-Based Health Center is much more than the traditional school nurse's office. We offer many health and medical services like your doctor's office (see list below). We do not replace your primary doctor and all of our services are provided at Lorna Byrne Middle School. The Student Health Centers at Evergreen Elementary, Lorna Byrne Middle School and Illinois Valley High School are operated by Siskiyou Community Health Center through an agreement with the Three Rivers School District.

#### **Who works at the Lorna Byrne Middle School Student Health Center?**

Our staff includes a Physician Assistant (PA) who can treat most health problems and prescribe medications, and a registered nurse (RN). Brief mental health counseling and/or referral to mental health/drug and alcohol services are also available. All staff are supervised by and have support of the Siskiyou Community Health Center physicians and medical director.

#### **What services are offered?**

We can take care of most of your student's health care needs at the Lorna Byrne Middle School Student Health Center. If there is an emergency or service we do not provide, we contact 911 or will make a referral to another health care provider. When the health center is not open or staff is unavailable, school personnel will follow Lorna Byrne Middle School guidelines for all emergency situations.

- ❖ Wellness and how to maintain it for a lifetime
- ❖ Physical examinations, routine and sports
- ❖ Mental health services and counseling
- ❖ Referrals to other health care providers
- ❖ Immunizations and flu shot
- ❖ Assessment of health strengths and challenges
- ❖ Nutrition education and weight management
- ❖ Diagnosis and treatment of minor illness
- ❖ Dental screening
- ❖ Vision and blood pressure screening
- ❖ Tests such as anemia, diabetes and infection

### **What about costs and billing?**

Siskiyou Community School Based Health Center wants to provide health care for all students who need it. Many of our services are provided at no charge; however, there are some services that we provide that require an exam and medical action that **may** result in a charge. Examples of some of these services include:

Sore Throat	Pink eye
Ear pain	Abdominal pain
Cough	Foreign body in eye
UTI symptoms	Follow-up visits
Sprain/fracture	Well Child checks
Head injury	Immunizations

If a visit does result in a charge, we will bill your insurance for you, including the Oregon Health Plan. We also offer a sliding discount program which is based on your family size and income. Anyone can apply for this program even if you have insurance. Additional information and an application are included in this packet. We encourage all families to complete an application. An office visit summary will be sent home after a billable service is provided.

### **What about parental consent?**

At the health center we require parental/guardian signed consent for a student to use our services.\* We support and encourage parental involvement in decisions about your student's health care.

### **What about confidentiality?**

Our health services and records are private and confidential. Health records will not become a part of your student's school record and will only be used by health center staff unless you give us written permission to share information.

Like other health care providers, the Lorna Byrne Middle School Student Health Center follows the guidelines of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA regulates how medical information may be used and disclosed and how you can get access to this information. We are required to give you a copy of our Notice of Privacy Practices and have you sign the Acknowledgment and Consent which is included in the packet.

### **What about appointments?**

Appointments are encouraged whenever possible. A parent may call and make an appointment or your student is welcome to come by and schedule an appointment. Hours will be posted on the clinic door and in the school bulletin.

Lorna Byrne Middle School esta dispuesto a ayudar a sus estudiantes hispano hablantes ya sus padres con traducciones cuando sea necesario. Los programas de esta escuela están abiertos a todos los estudiantes sin discriminar por razones de sexo, raza, ni impedimento físico.

Lorna Byrne Middle School can arrange to help Spanish speaking students and their parents with translation when necessary. The programs of this school are open to all students without discrimination for reasons of sex, race or inability to pay.

*\*Oregon State Law (ORS 109.610, ORS 109.640) requires a parent or guardian's signature for medical treatment for students less than 15 years of age, with the exception of treatment for sexually transmitted diseases and for birth control information and services. Oregon State Law (ORS 109.675) states that a student 14 years and older may obtain mental health and chemical dependency treatment without parental knowledge or consent.*



# Siskiyou Community Health Center

## STUDENT HEALTH CENTER

### LORNA BYRNE MIDDLE SCHOOL

101 South Junction Avenue Cave Junction, OR 97523

Main Office: (541) 592-6978 Fax: (541) 592-6702

### INFORMED CONSENT TO TREAT

Student Name: Last	First	Middle Initial	Date of Birth
--------------------	-------	----------------	---------------

Parent/Guardian Name	Relationship to Student	Home Phone
----------------------	-------------------------	------------

All services are provided at LBMS Health Center and by signing yes on this consent form you **do not** replace your regular doctor. Services that are provided to students may be billable. However, services will not be withheld for inability to pay. Unless you ask us in writing **not** to, we will go ahead and treat children with minor ailments with over-the-counter medications. This usually means cough drops for sore throats or coughs, generic Tylenol to reduce fever or headaches, generic Ibuprofen for headaches or cramps, generic Benadryl for allergic reactions. If your child has a breathing problem, we may also use an Albuterol inhaler according to our protocol. If you have any questions about our medication policies, please contact the Student Health Center at Lorna Byrne. Parent/guardian will be contacted by phone or letter if **prescription** medications are indicated.

Students will be encouraged to discuss visits with their parents; however, confidentiality will be provided at the student's request. Oregon State Law (ORS 109.610, ORS 109.640, and ORS 109.675) requires strict confidentiality regarding evaluation, diagnosis and/or treatment for sexually transmitted diseases, sexuality issues, pregnancy testing or mental health services. The Lorna Byrne Middle School Student Health Center will not dispense birth control supplies or provide abortion referrals.

- YES** I consent to health care services offered by the Lorna Byrne Middle School Student Health Center for the above named student. I understand that this consent is valid as long as my student is enrolled in an Illinois Valley middle or high school program.
- NO** I do *not* give my consent to services offered.

The American Academy of Pediatrics recommends children have a comprehensive physical exam performed every year. If you are interested in scheduling a well child exam for your child, please indicate by checking the box below:

- YES** I would like for my child to have a comprehensive physical scheduled at Lorna Byrne School Based Health Center. Please call me to schedule.
- NO** I do NOT want my child to have a comprehensive physical exam this year.

Parent/Guardian Signature

Date

PLEASE COMPLETE THE FAMILY HEALTH HISTORY





# Siskiyou Community Health Center

## STUDENT HEALTH CENTER

### FAMILY HEALTH HISTORY

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Medicine Allergies: \_\_\_\_\_

STUDENT MEDICAL HISTORY		FAMILY MEDICAL HISTORY																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<b>Has this student had any:</b> Chronic or recurrent illness such as diabetes, seizures, cancer, hepatitis, mono?	<input type="checkbox"/>	<input type="checkbox"/>	Has any family member died suddenly at less than 50 years of age of causes other than an accident?																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization/Surgeries?	<b>Signify health conditions which occur in the family. Include natural parents, brothers, sisters, and grandparents.</b> <table border="1"> <thead> <tr> <th>Yes</th> <th>No</th> <th>Who?</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Birth Defect</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bleeding Disorders</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Breast Problems</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cancer</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Gallbladder Problems</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Headaches</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Disease/Heart Attacks</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hepatitis</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>High Blood Pressure</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Kidney Disease</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Obesity</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sickle Cell Anemia</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Seizures</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Stroke</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Thyroid Disease</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tuberculosis</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other:</td><td>_____</td></tr> </tbody> </table>			Yes	No	Who?	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	_____	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defect	_____	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	_____	<input type="checkbox"/>	<input type="checkbox"/>	Breast Problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	_____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Attacks	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	_____	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	_____	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	_____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Other:	_____
Yes	No	Who?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Allergies				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defect				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Breast Problems				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Cancer				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Problems				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Headaches				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Attacks				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease				_____																																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Obesity	_____																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	_____																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	_____																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	_____																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Other:	_____																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Urinary, kidney problems, undescended testicles?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Missing or damaged organs (eye, kidney, testicle)?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Problems with heart or blood pressure?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain with exercise? Wheezing? Cough?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting with or without exercise?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches, anemia, bleeding or blood clot problems?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Allergies, asthma, severe bee sting reaction?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Learning disorders or slowed development?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Vision or hearing problems?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox? If yes, what year? _____																																																																																						
		<b>Does this student:</b>																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Wear eyeglasses or contact lenses?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Wear dental bridges, braces, plates?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Take any medication on a regular basis? (prescription or over-the-counter)																																																																																						
		<b>Is there a history of:</b>																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Concussion, loss of consciousness, convulsions?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Injuries to neck, knees, ankles?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Broken bones, joint injury, disease or dislocation?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<b>Has student had:</b>																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	2nd measles, mumps & rubella vaccine (MMR)?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B vaccine series?																																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	Year of last tetanus vaccine? _____																																																																																						

Date of last dental exam: \_\_\_\_\_ Date of last well child exam/sports physical: \_\_\_\_\_

Use the space below to explain any of the YES answers or to provide any additional information:

---



---



---

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_



# Siskiyou Community Health Center

## STUDENT REGISTRATION FOR SCHOOL-BASED HEALTH CENTER

Welcome to Siskiyou Community Health Center. We are committed to providing quality, cost-effective health care for you and your family. Please feel free to speak with your provider if you have any questions about your care. If you have any questions about clinic policies or procedures, please speak with the clinic manager

Date: \_\_\_\_\_

### STUDENT INFORMATION

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Jr. Sr. III

Other Names Known By: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male Female

### RESPONSIBLE PARTY NAME

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Jr. Sr. III

Relationship to Patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Gender: Male Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt/Unit: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Street Address (if different from above): \_\_\_\_\_ Apt/Unit: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

**May we leave a message?** Yes No **May we leave a message?** Yes No

Where does your child usually go for health care? \_\_\_\_\_

### INSURANCE

Private Insurance  Oregon Health Plan (OHP)  Self Pay

#### PRIMARY INSURANCE

*If you have insurance (including OHP) please fill out this section.*

Company: \_\_\_\_\_

**Policy/ID#:** \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

#### SECONDARY INSURANCE

*As a courtesy to our patients, we bill most secondary insurances.*

Company: \_\_\_\_\_

**Policy/ID#:** \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

As a Federally Qualified Health Center, we are able to offer services to all our patients, including the underserved, as a result of funding from Federal Grants. In order to receive grant dollars we are required to gather, on a yearly basis, the following statistics about the patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.

<p><b>STUDENT STATUS</b></p> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not Applicable	<p><b>STUDENT PRIMARY RACE</b></p> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian (White) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other	<p><b>Gross Annual Household Income</b></p> <p>\$ _____</p> <p><i>*Annual income amount is gathered for grant funding requirements.</i></p>
<p><b>PRIMARY LANGUAGE</b></p> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign Language <input type="checkbox"/> Other _____	<p><b>ETHNICITY</b></p> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic	<p><b>HOMELESS</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>Do you need an interpreter?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No		<p>_____ # Members in Family</p>

### PRIVACY PRACTICES – ACKNOWLEDGEMENT

I understand that the Student Health Center, operated by Siskiyou Community Health Center (referred to below as “This Practice”) will use and disclose health information about me which may include information both created and received by This Practice, may be in the form of written notice or electronic records or spoken words.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for insurance coverage and submit claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative, and business functions that support my physician’s efforts to provide me with, arrange and be reimbursed for qualify, cost-effective health care.

I acknowledge that this program complies with the HIPAA Privacy Security Act and a copy is available online at This Practice’s website at [www.siskiyouhealthcenter.com](http://www.siskiyouhealthcenter.com).

I have the right to revoke this authorization at any time, provided that I do so in writing and to the extent that This Practice has already used or disclosed the information based on this authorization. Unless revoked earlier or otherwise indicated, this authorization will expire 36 months from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The mission of Siskiyou Community Health Center is to identify and provide care for the primary health needs of our community in a professional and compassionate manner.**

*Siskiyou Community Health Center is a private, not-for-profit equal opportunity provider and employer.*



# Siskiyou Community Health Center

## SCHOOL-BASED HEALTH CENTER/DENTAL PREVENTION

### Sliding Discount Program Enrollment Form

Siskiyou Community Health Center wants to provide quality health care to our patients, regardless of their ability to pay. This Sliding Discount Program is based solely on family size and income in relation to the federal poverty level for services provided by our School-Based Health Centers (SBHCs) and Dental Outreach Programs.

Enrollment in this program is valid for the school year. To continue being considered for this program, a new Enrollment Form must be completed each school year. If eligible, your child will be able to receive medical care services at our SBHCs, as well as dental education and prevention service provided through our Kids Smile Dental Prevention Program, free of charge.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**List household members.** This includes yourself, spouse and dependents under 19 years old. Other adults in the household, even if related, are not included and will be considered separately.

Name (First and Last)	Relationship	Date of Birth	Gross Monthly Income
_____	SELF	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*I understand that the information I provide will be used to determine my/our ability to pay. The information above is true to the best of my knowledge. I understand that if I lie to get a reduced fee, I am committing fraud.*

Signature (Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_

Print Name (Parent/Guardian) \_\_\_\_\_

#### FOR OFFICE USE ONLY

#### DOCUMENTATION RECEIVED/DETERMINATION

Family Size (#): \_\_\_\_\_ Documented Family Annual Income: \$ \_\_\_\_\_

Qualifies for SBHC/Dental Outreach Slide:  Yes  No

\_\_\_\_\_  
Siskiyou Community Health Center Signature

\_\_\_\_\_  
Date







# DENTAL PREVENTION PROGRAM Consent to Treat



With parental permission, your child may participate in the **KIDS SMILE DENTAL PREVENTION PROGRAM** and will receive dental education and prevention services provided at their school or daycare. This service is not necessary for children already receiving regular dental treatment. This dental screening and education is open to **ALL** children regardless of income or insurance status. We will bill your insurance company if the information is provided. **If your child is uninsured**, he/she may be eligible to receive these services for free under our Sliding Discount Program. To be considered for this discount, please complete the attached application. Remember to sign and date the form.

If you would like your child to receive these services, please fill out this consent form and return it to your child's school or day care center.

Name of Student \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex (M/F) \_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_  
 Does your child have any medical problems or allergies? (Please explain) \_\_\_\_\_

Does your child currently take a daily prescription fluoride tablet?      No      Yes  
 Please circle the number of months since the last time your child saw a dentist:  
                  3-6 months                      6-9 months                      Over 12 months                      Never Seen

Dentist's Name \_\_\_\_\_  
 Do you have dental insurance:      No      Yes (Please circle type of insurance below)  
     OHP—**Advantage**      OHP—**Capitol**      OHP—**MODA**      OHP—**Open Card**      OHP—**Willamette**  
 Insurance Patient ID #: \_\_\_\_\_  
 Private Dental Insurance: \_\_\_\_\_ Patient ID #: \_\_\_\_\_  
 Primary Holder of Insurance: \_\_\_\_\_

I authorize the following for my child: (Please mark the boxes below)

**Dental health screening**  
 **Fluoride varnish application** (As need indicates)  
 **Dental sealants on molar(s)**  
 (A thin preventative coating applied into chewing surface grooves to keep bacteria out.)

If you have any questions please contact:  
 Amy Tripp, BSDH at (541) 295-8070



If you said **YES** to screening, flouride and/or sealants, your signature indicates:

As the legal parent/guardian, I hereby consent to the release and exchange of information, including any personal health information, between the dental sealant staff, school staff, insurance carriers, the child's dentist, applicable Coordinated Care Organization, and/or Dental Care Organization of record. I acknowledge that this program complies with the **HIPAA Privacy Security Act** and a copy is available online at our website at [www.siskiyouhealthcenter.com](http://www.siskiyouhealthcenter.com).

You have a right to revoke this authorization at any time, provided that you do so in writing and to the extent that we have already used or disclosed the information based on this authorization.

Unless revoked earlier or otherwise indicated, this authorization will expire 36 months from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Parent /Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

**\*\*PLEASE COMPLETE ALL INFORMATION ON BOTH SIDES OF THIS FORM\*\***



## "Kids Smile" Dental Prevention Program



- The **"Kids Smile" Dental Prevention Program** is an opportunity for your student to receive dental preventative treatments which may include an oral health screening, oral hygiene education, fluoride application and sealants. School sealant programs can reduce cavities by 50%.<sup>2</sup>
- These services are available at **no cost to you**; please see the details on the next page.
- Each participating child will receive **a report of services completed**.
- **More than half of all children have a cavity by age nine.**<sup>1</sup> Dental disease, if left untreated, may cause pain, infection, loss of teeth and can lead to serious health risk.
- **1 in 5 children have untreated decay.**<sup>1</sup>
- **Fluoride varnish applications 2 to 4 times per year** can reduce cavities in permanent teeth by 43% and in baby teeth by 37%.<sup>3</sup>
- **Sealants** are the most effective cavity preventing measure. **A child 6-9 years old child will benefit most** from this thin protective coating applied on molars.
- **All students are invited. It's important to complete both the *Consent to Treat and Slide Discount Application forms for your child to receive these services.***

<sup>1</sup> Oregon Health Authority. (2012). *Smile Survey*. Retrieved from <https://public.health.oregon.gov/PreventionWellness/oralhealth/Pages/Oral-Health-Publications.aspx>

<sup>2</sup> Community Preventive Services Task Force. (2013). *The Community Guide*. Retrieved from [https://www.thecommunityguide.org/sites/default/files/assets/Oral-Health-Caries-School-based-Sealants\\_0.pdf](https://www.thecommunityguide.org/sites/default/files/assets/Oral-Health-Caries-School-based-Sealants_0.pdf)

<sup>3</sup> Cochrane Collaboration. (2013). *Fluoride varnishes for preventing dental caries in children and adolescents*. Retrieved from [http://www.cochrane.org/CD002279/ORAL\\_fluoride-varnishes-for-preventing-dental-caries-in-children-and-adolescents](http://www.cochrane.org/CD002279/ORAL_fluoride-varnishes-for-preventing-dental-caries-in-children-and-adolescents)

### **If you have any questions please call:**

Kids Smile Dental Prevention Program  
Amy Tripp, BSDH, Expanded Practice Dental Hygienist  
(541) 295-8070

