2018 DENTAL CLINIC

FES & RBMS

Whiteside County Health Department will be having a dental clinic again for all kids in Kindergarten through 8th grade. They will be coming to our schools on April 10 and 11th.

This is a **FREE** service for free and reduced lunch kids.

If you have dental insurance they will file it for you.

If not eligible for free and reduced lunch or no insurance there is a $40 fee.

There is a state law requiring dental exams in Kindergarten, second, and sixth grades. If you have not turned in your exam sheet yet, this would qualify for that. Also if your child will be in 2nd or 6th next year, this exam will be good for next year. To be seen this form needs to be filled out and signed.

Please turn in these slips by April 4th. Linda Rogis R.N.

WCHD School Dental Clinic Program
Permission Form
2017-2018

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: Epilepsy 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.

This section needs filled out

☐ **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 Company Name:**

Insurance Company's Address:	*Insurance Co's Phone #:*
Insured's SSN or ID#:	***Group #:***
Insured's Name:	*Insured's Employer:*

Insured's Birthdate: / / | *Address:* | *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 within 365 days from this 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	$1,307 or under	$1,308 – $1,860	$1,861 or greater
2	$1,760 or under	$1,761 – $2,504	$2,505 or greater
3	$2,213 or under	$2,214 – $3,149	$3,150 or greater
4	$2,665 or under	$2.666 – $3,793	$3,793 or greater
5	$3,118 or under	$3,119 – $4,437	$4,438 or greater
6	$3,571 or under	$3,572 – $5,082	$5,083 or greater
7	$4,024 or under	$4,025 – $5,726	$5,726 or greater
8	$4,477 or under	$4,478 – $6,371	$6,372 or greater
Each additional household member	Add $453	Add $645	Add $645

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.