School-Based Dental Center

Medical/Dental History Form

617 Riverside Avenue ■ Burlington, VT 05401 ■ Tel No. 802-652-1050

1. The Community Health Centers of Burlington (CHCB) offers a great kid's School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School, 6 Archibald Street, Burlington.
2. All children who are Burlington School District students or siblings of students, who are enrolled in Medicaid, Dr. Dynasaur or are low-income and uninsured AND have not seen a dentist in the past year, are welcome. If you are low-income and uninsured, we'll help you meet with our Eligibility Services staff to apply for programs and/or our Sliding-Fee Scale Program.
3. Just fill out this form and sign it (read the back for translation if needed) and send it back to the school. If you need help with this process, we'll help you fill out the form. Please contact your school nurse, school liaison, or CHCB's Dental Center at 652-1050 or 658-4869. Please check box that applies.

Once your child is signed up, the school and the Community Health Centers will take care of everything else for you. If your child does not attend the Integrated Arts Academy at H.O. Wheeler, transportation can be arranged. Remember, parents are always invited to dental appointments, too. Dental care for your child has never been so easy!

Please make sure you fill out the form **completely** and **sign it on each page.**
Each child needs a registration form. For another form, just call the Integrated Arts Academy at 658-4869 or CHCB's Dental Center's main telephone number 652-1050.

Today's Date ____/____/____ School Child Attends: _____

Child's Name: _____ (Last) _____ (First) _____ (MI) **Child's Date of Birth:** __/ ____/ ___

Child's Social Security Number: ____/____/____ **Primary Language:** _____

Street Address: _____ City _____ State _____ Zip Code _____

Name of Child's Physician: _____ Phone number _____ Last Visit _____

Name of Child's Dentist: _____ Phone number _____ Last Visit

Student's Race

☐ African-American ☐ Native American Primary Language if not English: _____

☐ Asian-American ☐ Pacific Islander

☐ Caucasian/White ☐ Multi-racial Ethnicity/Ethnic Origin ☐ Hispanic ☐ Non-Hispanic

Parent/Guardian Information

Name of Person Legally Responsible for Child: _____ Relationship: _____

Home # _____ Work # _____ Cell # _____ Email: _____

Alternate Contact Person: _____ Home # _____ Work # _____

Cell # _____ Relationship: _____ Email: _____

Insurance Information

Does your child have Medicaid or **NO** insurance? Please explain.

_____

☐ **Dr. Dynasaur/Medicaid Number #** _____ ☐ **No Dental Insurance**

Burlington School District: *I hereby authorize the school nurse, social worker, and other school agents to refer my child to one or more of the Service Organizations listed in my Consent Form for health and/or dental services.*

_____

(Signature of parent/guardian) (Date)

☐ Interpretation or Translation offered and understood.

_____

(Signature of person completing form if not parent/guardian) (Contact number)

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Child's Name: _____ **Child's Date of Birth:** _____
(Last) (First) (MI)

Medical/Dental History Form

Your child's overall health, as well as any medications that your child takes could have an important impact on your child's medical/dental care.

Please answer each of the following questions completely.

Have you ever been told your child needs antibiotics prior to dental work? ☐Yes ☐No
Has your child had any trouble with previous dental work? ☐Yes ☐No

If yes, please explain: _____

_____

Medical History

Does your child have any of the following diseases or problems? If **yes** please check the corresponding box:

YES	NO		YES	NO	
☐	☐	Asthma	☐	☐	Convulsions/Epilepsy
☐	☐	Cancer	☐	☐	Tuberculosis
☐	☐	Hepatitis	☐	☐	Abnormal Bleeding
☐	☐	HIV/AIDS	☐	☐	Sinus Trouble
☐	☐	Hemophilia	☐	☐	Anemia
☐	☐	Diabetes	☐	☐	Rheumatic Fever
☐	☐	Allergies	☐	☐	Handicap/Disability
☐	☐	Congenital Heart Defect	☐	☐	Heart Murmur Antibiotic needed per Dr. _____

Any other medical problems not listed (Please Explain):

_____

_____

List any medications your child is taking (Please include prescription and non prescription drugs)

1._____ 3._____

2._____ 4._____

Is your child allergic to or had a bad reaction to any of the following?

YES	NO		YES	NO	
☐	☐	Local anesthetics (Novocain)	☐	☐	Penicillin or other antibiotics
☐	☐	Latex	☐	☐	Sedatives, barbiturates, or sleeping pills
☐	☐	Aspirin	☐	☐	Iodine
☐	☐	Codeine or other narcotics	☐	☐	Other:

Please sign below to ensure proper dental/ health care for your child. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to notify the healthcare provider office of any changes in my child's medical history. I also authorize treatment such as radiographs, routine check-ups (including fillings and extractions) and fluoride to be given to my child as needed at each dental visit.

_____ _____
(Signature of parent/guardian) (Date) (Signature of dentist reviewing history) (Date)

☐ Interpretation or Translation offered and understood.

_____ _____
(Signature of person completing form if not parent/guardian) (Contact number)

Parents are encouraged to attend their child's appointments. For questions about dental services or to reschedule your child's dental appointment call 24 hours prior to appointment time at the Integrated Arts Academy at 658-4869 or CHCB's Dental Center's main telephone number 652-1050. Late arrival to your appointment may require rescheduling.

Child's Name: _____ Child's Date of Birth: _____
(Last) (First) (MI)

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Consent to Treatment, Information Release & Payment Assignment Form

Must be completed in advance of participation in the School-Based Dental Center

The School-Based Dental Center has arranged with the Service Organizations listed below to provide dental services for the Burlington School District students. I understand I am providing this Consent for the purpose of obtaining professional dental services for my child listed below and for the other purposes described in this Consent. I further understand this Consent covers only dental services provided at the School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School and at the Community Health Centers of Burlington (CHCB).

Acknowledgment of Release of Information

The School-Based Dental Center is a collaboration of the Burlington School District and the Community Health Centers of Burlington.

To allow the team to work together effectively, we ask parents/guardians to authorize the persons and organizations involved in your child's treatment to share information when necessary to carry out that treatment.

By signing this consent, I authorize the Service Organizations described below, their individual service providers and their supervisors to exchange and discuss appropriate information pertaining to my child only when needed for my child's treatment.

I also authorize the School-Based Health Center and Service Organizations to communicate with my child's regular primary care provider and/or dentist.

The Service Organizations Consist of:

Burlington School District social workers, school health personnel, counselors and principal
Community Health Centers of Burlington (CHCB)

Consent to the Provision of Services

I authorize each of the Service Organizations listed above to see my child at the School-Based Dental Center:

- ☐ Whenever my child needs dental care
- ☐ Only when I have given specific written permission (except in the case of a medical, dental or behavioral health emergency)
- ☐ Only when I am present (except in the case of a medical, dental or behavioral health emergency)

Assignment of Benefits

I hereby assign to the Service Organizations any and all payments to which I am entitled under Medicaid or any health insurance policy for health care or dental health services rendered to my child by any Service Organization as long as the charges for services by the Service Organization(s) do not exceed the Service Organization's regular charges. I further authorize each Service Organization to bill and receive payment directly from Medicaid or my insurance carrier(s) for those services that the Service Organization delivered and for which I may be entitled to insurance coverage. I also authorize each Service Organization to give to Medicaid or my health insurance carrier(s) any information necessary for billing purposes for services provided for such periods of time as my child has received or is receiving primary health care or dental health services.

Emergency Contact/Changes in Health Status or Custody

I understand that as a condition of this Consent, if any of the Service Organizations judge my child to be a serious danger to him/herself or others, then the Service Organization (s) reserve the right to inform a physician, others who may be at risk, designated emergency contacts and appropriate emergency services. I further agree that I will promptly inform the School-Based Dental Center staff in writing of 1) any change in my child's physical or dental health and 2) any change in the custody or guardianship of my child which affects my ability to provide this Consent on behalf of my child.

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Child's Name: _____ **Child's Date of Birth:** _____
(Last) (First) (MI)

Confidentiality & Privacy

I understand the Service Organizations will protect the privacy of my child's health and educational records to the extent required by federal and state law. I understand that I may revoke this authorization at any time (except to the extent that any Service Organization has already taken action based upon my prior consent) if I make a written statement revoking the authorization and deliver it to the Burlington School District, Grant Programs, 150 Colchester Avenue, Burlington, VT 05401.

I have read and understand the Notice of Privacy Practices from the Community Health Centers of Burlington and acknowledge a copy of such notice will be provided to me at my request.

Agreement Concerning Transportation to And from the School-Based Dental Center at the Integrated Arts Academy at The H.O. Wheeler School

Dental services for elementary and middle school students are provided at the School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School. The State of Vermont has contracted with SSTA to provide transportation services for Medicaid eligible students to and from Burlington's schools and the School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School.

a) If my child needs transportation as indicated below, I consent to having one of the Service Organizations schedule SSTA transportation to take my child to and from the H.O. Wheeler School for dental services, at no cost to me.
b) I agree that SSTA may seek reimbursement from Medicaid for such transportation services.

If My Child is Seen at the End of the School Day, My Child:

☐ May walk home with their siblings named _____

☐ May walk home with a friend(s) named _____

☐ Should be transported to babysitter / child care provider named _____

located at _____

with this telephone number _____

☐ Should be transported home and dropped only if one of these adults is present:

_____

Name of Child: _____

I (parent or guardian name), _____ have read the above material and understand its meaning. My signature below is an acknowledgment that I have reviewed this form, understand the information and consent to all of the actions described above. My signature also attests to the accuracy of the information provided on both sides of this form.

_____ _____
(Signature of parent/guardian) (Date)

☐ Interpretation or Translation offered and understood.

_____ _____
(Signature of person completing form if not parent/guardian)) (Contact number)

Parents are encouraged to attend their child's appointments. For questions about dental services or to reschedule your child's dental appointment, call 24 hours prior to appointment time at the Integrated Arts Academy at 658-4869 or CHCB's Dental Center's main telephone number 652-1050. Please also call if you know your child will be late for an appointment. Your dental provider may need to reschedule your appointment to allow enough time for treatment.