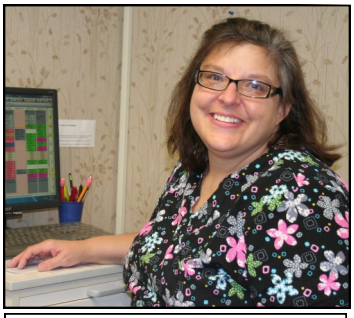
Brooker Memorial
Preparing Children for Life-long Success

157 Litchfield Street, Torrington, CT 06790
(p) 860-489-1328 (f) 860-489-4761 (w) brookermemorial.org

DENTAL CARE AT YOUR SCHOOL!!



Debra Ravlin, RDH, is the primary hygienist for the school dental program.

DEAR PARENTS/GUARDIANS, 2016- 2017

I am pleased to inform you Brooker Memorial, Pediatric Dental Center will again provide an in-school preventive dental care program to all children in grades K-8 in Region One elementary schools. Children in grades K-8 will be offered dental cleanings, caries risk assessments, fluoride and sealants at school during the 2016-2017 school year. **The program is open to all students whether or not they have dental insurance.** This program is made possible through a partnership of the participating schools, The Foundation for Community Health in Sharon and Brooker Memorial, Pediatric Dental Center in Torrington.

A registered dental hygienist from Brooker Dental will provide these services to your child. If your child needs sealants, they will be scheduled to see the hygienist again at school on another day. If your child needs to see a dentist for additional treatment, this will be detailed on the report the hygienist will mail to you after your child's visit. If your child maintains regular dental appointments with your family dentist or Brooker Dental, you are still entitled to participate in this program. The goal of the program is to make it easier for families to obtain dental care for their children. We know it can be difficult to take time off from work and travel long distances for dental care.

All children in grades kindergarten through eight will participate in an educational program presented by Brooker's Dental Staff. This will introduce them to the dental program and educate them on oral health. If you would like your child to receive preventive dental care through this program, simply fill out the information and consent forms included in this packet and return them to the school nurse. If you would like more information about the program, please call your school nurse or Brooker Dental at 860-489-1328.

Families will not be billed for services provided at school. If dental insurance information is available, we will submit a claim to help offset the cost of this program. We look forward to providing dental care to your child!

Sincerely,

Cathy C. Coyle
Brooker Memorial Executive Director

Archana Karanki, D.M.D.
Brooker Memorial Dental Director

*** please keep this page ***

Student Medical History (2016-2017)

Student Name_____ Grade_____

School _____Teacher _____

Student Information

Is the student allergic to or has he/she had a reaction to:	Y	N
Any foods		
Any medicines (Penicillin or other antibiotic)		
Local Anesthetics		
Latex		
Please explain any allergies:		
Has the student had any serious injuries or sports-related injuries?		
Has the student ever been hospitalized overnight?		
Has the student had any surgery?		
Is the student taking any medication now?		
If yes, please list:		
Does the student have any heart problems, such as a heart murmur or congenital heart defects?		
Does the student have any health problems?		
Is the student currently seeing a physician for any problems?		
Has there been any change in the student's health during the past year?		
Does the student have any behavior or learning problems?		
Dental Health Questions		
Does the student have his/her teeth cleaned at least once a year?		
Are any of the student's teeth causing him/her pain?		
Does the student smoke or use chewing tobacco?		
Do the student's gums bleed while brushing or flossing?		
Does the student take a fluoride supplement?		

OFFICE USE:

_____

PROVIDER SIGNATURE DATE

Student Information

Physician's Name
Physician's Address
Physician's Phone
Date of Last Physical Examination
Dental History
Is this the student's first dental visit? Circle one Yes No If no, please complete the following
Name of Last Dentist Seen
Dentist's Address /Phone
Date of Last Dental Visit
Was the student seen in the school dental program in prior years? Circle One Yes No
Has the student ever been seen at the Brooker Memorial Dental Center? Circle One Yes No

Has the student had any of the following illnesses or conditions?

Condition	Y	N	Condition	Y	N
Anemia or blood disorders			Mononucleosis		
Asthma			Pneumonia		
Bladder or kidney infections			Rheumatic fever or heart disease		
Cancer			Scoliosis		
Chicken pox			Seizures		
Diabetes			Severe acne		
Endocrine/gland disease			Tuberculosis		
Hepatitis			Thyroid disease		
Mental illness/ depression			Ulcer/digestive problems		

Does the student have any disease, condition or problem not listed above?

If yes, please explain_____

_____

Other Notes or Information_____

_____

X_____

PARENT/GUARDIAN SIGNATURE DATE

*** please fold in half and tape or staple before returning ***

Student Information/Permission (2016-2017)

Last Name_____ First Name _____MI_____

Mailing Address_____City_____State_____ Zip_____

Date of Birth: _____ Sex: _____M _____F

Name of Legal Guardian_____ Relationship to Student _____

*Email address*_____ Telephone_____

Address if different than student's _____

Student's Insurance: _____HUSKY _____Private (Insurance Company_____) _____No Dental Ins

Subscriber's name:_____ Employer_____

Subscriber's DOB:_____ Address if different than above_____

Student's or Subscriber's ID # (HUSKY ID # from gray Connect card)_____

Families will not be billed for services provided at school.

	Y	N
I give permission for my child to be treated in the school and receive services deemed necessary by the dental staff of Brooker Memorial. This includes dental cleanings, caries risk assessments, fluoride and application of sealants.		
I certify that the health information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student's health.		
I agree that messages can be left for me on the telephone number provided in the Student Information section of this form.		
I agree to ensure that my child receives any follow-up treatment outlined by the dental hygienist or dentist.		

	Y	N
If applicable, Release of Information and Payment Authorization: I authorize the release of any medical or other information necessary to process my child's insurance claim. I also authorize payment of insurance dental benefits to Brooker Memorial for services provided.		
Authorization for Exchange of Health & Education Information: I hereby authorize Brooker Memorial to exchange health and education records with my child's school district for the purpose of providing care and treatment to my child.		
This authorization is valid while my child is enrolled in the Region One school district. I understand I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand if I refuse to sign, such refusal will not interfere with my child's ability to obtain dental care. I agree that a copy of this authorization is as valid as the original.		
I hereby authorize Brooker Memorial to communicate with my child's dentist if I have listed him/her on this form. My child's dentist may be notified by Brooker Memorial about needed follow up care or other relevant dental information, including date of their school visit with Brooker's hygienist (for coordination of treatment and billing)		
Consent and Acknowledgement of Privacy Practices: I consent to the use and disclosure of my child's protected health information by Brooker Memorial (Brooker) to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. as long as such information is used or disclosed in accordance with Connecticut and Federal law. I understand that information regarding how Brooker will use and disclose my child's information can be found in Brooker's Notice of Privacy Practices. I understand that this consent is effective for as long as my child is enrolled in the Region One school district.		

By signing below, I understand and acknowledge the following: 1) I have read and understand this consent; and 2) I have received Brooker's Notice of Privacy Practices currently in effect or have access to a copy at www.brookermemorial.org.

PRINTED NAME OF LEGAL GUARDIAN X _____

X_____DATE_____

SIGNATURE