STAR COMMUNITY HEALTH

DENTAL VAN HEALTH SERVICES
STUDENT INFORMATION & CONSENT

DENTAL VAN HEALTH SERVICES — Please complete and return to the school health room

Student's Name: _____ Date of Birth: _____ ☐ Male ☐ Female

School: _____ Grade: _____

DENTAL HEALTH CARE SERVICES:

___ **YES,** I consent for my child to receive **DENTAL SERVICES** on the Star Community Health mobile van, which may include: comprehensive dental examination, oral hygiene instructions, radiographs (x-rays), dental cleanings, fluoride treatment, sealants (thin plastic coatings placed over the chewing surfaces for the back teeth to protect them from developing tooth decay), fillings (with a tooth-colored material), extractions (removal of tooth), stainless steel crowns (silver colored caps), and pulpotomies (nerve treatment). This treatment may include administration of topical and injectable local anesthesia.

___ **YES,** I consent for my child to receive SDF (Silver Diamine Fluoride – a liquid substance used to help kill bacteria, however it will discolor the cavity to a permanent black color.) I am verifying I have seen photographs of SDF application on teeth and that my child does not have any allergies to silver.

___ **NO,** I do not wish for my child to receive dental services on the Star Community Health dental van.

MEDIA CONSENT:

___ **YES,** I hereby consent for Star Community Health and its affiliates to take photographs, interview, or make video and/or audio recordings of my child.

___ **NO,** I do not wish for my child to be photographed, videotaped and/or interviewed by Star Community Health.

Student Information Dental Van Health Services

Name of Parent/Guardian: _____ DOB: _____ Relationship to Child: _____

Address: _____
Street Number City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Person: _____ Phone Number: _____
Other than Parent / Legal Guardian

An annual Medical History form must be updated yearly on your child in order to continue receiving care on the dental van. Students with expired medical histories will not be scheduled for dental services.

Medical Doctor or Clinic: _____ Office Location: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Dental Insurance Information (please complete as much as you know):

Name of Insurance: _____

Policy Number: _____ Group Number: _____

Does your child currently receive dental care at another dentist besides Star Community Health? ☐ Yes ☐ No

YOUR CHILD MAY NOT USE THE DENTAL VAN IF THEY HAVE SEEN A PRIVATE DENTIST WITHIN THE PAST 6 MONTHS.

Date of last dental visit at provider other than Star Community Health: _____

This consent will be in effect until the student graduates or ceases to be enrolled at the student's present school district or until this consent is revoked by the parent/legal guardian by sending a written notification to the student's school nurse.

By signing this consent, I agree to the terms and conditions regarding the **PAYMENT FOR SERVICES** and **SHARING of HEALTH INFORMATION** as explained in the accompanying **PROGRAM DESCRIPTION** pages. I have received the **Notice of Privacy Practices,** which is included. I understand that signing this consent form is not a guarantee my child will be scheduled for treatment within a certain time frame.

X _____ _____ _____ _____
Parent/Guardian Signature Date Time Parent/Guardian's Printed Name

_____ _____ _____ _____
Student's Signature (if 18 or older) Date Time Student's Printed Name

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STAR COMMUNITY HEALTH

DENTAL VAN HEALTH SERVICES

MEDICAL HISTORY FORM &
HIPAA PRIVACY AUTHORIZATION

Child's Medical Information (please answer all questions):

1. Is your child allergic to any medications including penicillin? ☐ Yes ☐ No
   If yes, please list: _____
2. Does your child have any allergies including nuts, food and seasonal? ☐ Yes ☐ No
   If yes, please list: _____
3. Does your child currently take any medications? ☐ Yes ☐ No
   If yes, list names of medications: _____
4. Has your child had any operations, serious injuries or hospitalizations? ☐ Yes ☐ No
   If yes, please explain: _____
5. Does your child have or had any of these problems? (Please check all that apply)

☐ ADHD	☐ Heart Condition	☐ Pregnancy	☐ Learning Disabilities
☐ Autism	☐ Heart Murmur	☐ Sinus Trouble	☐ Mononucleosis (mono)
☐ Asthma or wheezing	☐ Mitral Valve Prolapse	☐ Stroke	☐ Tuberculosis (TB)
☐ Bleeding problems	☐ High Blood Pressure	☐ Ulcers	☐ Hepatitis (A, B or C)
☐ Cancer _____	☐ Kidney Disease	☐ Rheumatic Fever	☐ HIV/Aids
☐ Diabetes	☐ Eye Problems	☐ Behavioral Problems	☐ Other Conditions: _____
☐ Liver Disease	☐ Psychiatric Problems	☐ Hearing Impaired	_____

6. Please list any dental concerns: _____
   _____

HIPAA PRIVACY AUTHORIZATION & MEDIA RELEASE FORM

1. **Authorization to Disclose.** I authorize Star Community Health and its affiliates to use and disclose health information about my child obtained by Star Community Health in providing health services to my child. The purposes of such uses and disclosures would be for communicating with my child's school and its employees and agents, including the guidance counselors and school nurse, as Star Community Health and the school determine is in my child's interests.
2. **Refusal to Sign.** I understand that I may refuse to sign this authorization. Star Community Health may not refuse to treat my child based on my refusal to sign this Authorization.
3. **Expiration of Authorization.** This Authorization shall be in force and effect until my child graduates or ceases to be enrolled at his/her present school, at which time this Authorization expires. Once this Authorization has expired, Star Community Health may no longer use or disclose my child's health information for the purposes listed in this Authorization unless I sign a new Authorization. However, materials that were created prior to the expiration of this Authorization may continue to be used or disclosed for the purposes listed in this Authorization.
4. **Revocation of Authorization.** I understand that I have the right to revoke this Authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my Authorization. If I wish to revoke this Authorization, I will send a written request to: Star Community Health, 511 East 3rd Street, Suite 260, Bethlehem, PA, 18015, Attention: Dental Program Director.
5. **Further Disclosure.** I understand that information used or disclosed pursuant to this Authorization may be further reproduced, copied or disclosed by those who receive or view the information, and the laws governing patient privacy may no longer protect the information.

X_____ _____ _____ _____

Signature of Parent or Guardian | Date | Time | Printed Name of Parent or Guardian and his or her relationship to child

_____

Child's Name

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