ERIE COUNTY HEALTH DEPARTMENT
COMMUNITY HEALTH CENTER

Edison

Let Your Smile Shine!

Our Mobile Health Vehicle is coming to your school!

Wednesday, October 11, 2023

9am-3pm

at Edison Elementary

Dental Health Screenings and Cleanings

*All services rendered will be billed to insurance. Reduced out of pocket costs & free services to those who qualify. No child will be denied services due to inability to pay.

For your convenience, call 567-867-5174 to pre-register. Walk-in appointments are available.

Dear Parent(s)/Guardian(s),

August 30th, 2023

Erie County Health Department/Erie County Community Health Center has partnered with Edison Local School District to provide onsite school-based dental services. Dental services will be provided on the Erie County Health Department/Erie County Community Health Center's Mobile Dental Vehicle which is designed and outfitted as a Mobile Dental Center to provide comprehensive and quality dental care in the community setting. Dental screenings and cleanings are available to all students regardless of insurance or ability to pay. All services rendered will be billed to insurance, if applicable. Reduced out of pocket costs and free services are available. No child will be denied services due to inability to pay. The Mobile Dental Vehicle will be at the following school on the listed dates and times:

Location:	**Edison Elementary School**
Date:	Wednesday, October 11th, 2023
Time:	9am-3pm

What to expect?

Children will receive dental services on our Mobile Dental Vehicle unit by a licensed dentist and dental assistant. The services provided may include all or some of the following:

- Dental examination
- X-rays, as needed
- Fluoride treatment
- Sealants
- Referrals, as needed

What is the follow-up?

According to the American Dental Association, children should receive a dental cleaning every six months to maintain healthy teeth and gums. After a child is seen on the Mobile Dental Vehicle, a staff member from the Erie County Community Health Center will reach out to the parent/guardian and review details pertaining to the child's dental appointment.

How do I make an appointment for my child?

For your convenience, please call the Erie County Community Health Center Centralized Scheduling office at 567-867-5174 to pre-register your child's appointment. Walk-in appointments are available.

What paperwork do I need for my child to participate?

Please complete and turn in the 2023 MHV Dental Consent Form along with a copy of the parent/guardian's photo ID (for minor children) and insurance card, if possible. Please submit the completed consent and copies in your child's daily folder or to your child's homeroom teacher ahead of time. Completed consent forms and a copy of the parent/guardian's photo ID and insurance card will be given to the Erie County Community Health Center staff prior to the child's appointment. **For preschool children, it is a school requirement that the parent/guardian attend the dental appointment with their child. The school recommends that children who attend morning preschool schedule their child's dental appointment in the afternoon. Conversely, children who attend afternoon preschool should schedule their child's dental appointment in the morning. For children in K-3rd grade, it is not necessary for you to attend the dental screening with your child, but you are welcome.**

For any questions, please contact:

Nicole Ziegler, RN
Primary Care and Clinical Services Director
(419) 626-5623 Ext: 5127
nziegler@echdohio.org

Instructions for Completing School Based Health Center Consent Form for Dental Services on the Mobile Health Vehicle

Page 1:

1. Review the consent form and complete.
2. Name of Student/Date of Birth/Grade.
3. Check the box. *"Yes! I consent this form to act as a* **valid informed consent** *for treatment at all sites of the Erie County Community Health Center."*
4. Check the box, "Yes! I consent for my child to receive **Dental Care** through the School Based Health Center."
5. Complete Parent/Guardian Signature/Print Name/Date.
6. Complete the authorization of releasing medical records from the following facilities section.
7. Check the box, if applicable. "*The School Based Health Center to release records to my child's primary care and/or dentist as listed above."*
8. Complete the signature/print name/date.
9. Complete the Parent/Guardian Information.
10. Complete the Health Insurance section, if applicable.

Page 2:

1. Complete the Dental Insurance section, if applicable.
2. Complete the Student's Health History section.
3. Complete the Student/Family History section.

Return all completed and signed consent forms to the school prior to your child's scheduled dental visit

Erie County Health Department/Erie County Community Health Center

School Based Health Center Consent Form

Name of Student _____ Date of Birth _____ Grade _____

I understand that the Erie County Community Health Center will provide health services. One consent form per student must be signed annually and on file at the health center for the student to receive these services. By marking "yes" I consent to the following:

☐ **Yes!** I consent for this form to act as **valid informed consent** for treatment at all sites of the Erie County Community Health Center.

☐ **Yes!** I consent for my child to receive **Dental Care** through the School Based Health Center.
(examples: cleanings, x-rays, sealants, fluoride, exams)
***Parent/guardian of minor must be present for fillings, endodontic procedures and/or extractions**

I hereby authorize the School Based Health Center to provide the services as indicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served regardless of the ability to pay. I hereby authorize the School Based Health Center staff members to release any medical records required by the insurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, the School Based Health Center staff members will use and share Personal Health Information for 1.) Treatment of my child's health conditions and maintaining the continuity of my child's care, 2.) Payment for health services provided to my child, and 3.) Routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices documentation is available to me at the location(s) my child receives his/her health care services and on the Erie County Health Department/Erie County Community Health Center website.

Parent/Guardian Signature _____ Print Name _____ Date _____

*Note: In accordance with Title X law, parental consent is *not* required for health services for individuals age 14 and older for medical treatments for venereal disease or HIV, diagnosis of pregnancy, or preventative services.

I hereby authorize the release of medical records from the following facilities to assist in the treatment and/or for continuity of care of my child:
(check all that apply)

☐ The school to release records on a "need to know basis" to the School Based Health Center. (example: immunization record, class schedule, parental contact, address, phone number, medical/behavioral health conditions, health screenings, medications, health care plans, attendance information, etc.)

☐ My child's primary care physician to release any requested records to the School Based Health Center.
Physician's Name/Office _____ Phone Number _____

☐ My child's dentist to release any requested records to the School Based Health Center.
Dentist Name/Office _____ Phone Number _____

☐ The School Based Health Center to release records to my child's primary care physician and/or dentist as listed above.

Parent/Guardian Signature _____ Print Name _____ Date _____

Parent/Guardian Information

Mother/Guardian _____ DOB_____ Home Phone _____ Alt Phone _____
Father/Guardian _____ DOB_____ Home Phone _____ Alt Phone _____
Parent(s)/Guardian Address _____

Health Insurance (Please circle and complete, if applicable) **Medical Insurance:**

Private Insurance Medicaid Uninsured
Insurance Policy Holder's Name: _____ Insurance Policy Holder's DOB: _____
Insurance Policy Number _____ Insurance Policy Group Number _____

Dental Insurance: Private Insurance Medicaid Uninsured

Insurance Policy Holder's Name: _____ Insurance Policy Holder's DOB: _____

Insurance Policy Number _____ Insurance Policy Group Number _____

Student's Health History

Primary Care Physician: _____ Phone: _____ Date of Last Exam: _____

Primary Dentist: _____ Phone: _____ Date of Last Exam: _____

Allergies to medications, foods, bee stings, etc.....: _____

Current medications child is taking:

_____

Important health history: (Pregnant, history of cancer, tumors, seizures, diabetes, tuberculosis, and heart murmurs, etc...)

_____

Has your child ever been hospitalized overnight in the past year? ☐ Yes ☐ No If yes, why? _____

Has your child had surgery in the past year? ☐ Yes ☐ No If yes, please describe: _____

Student/Family History

	Yes	No	Unsure	Age of onset	Student	Mom/Dad	Brother/Sister	Grandparent
Alcohol/Drug use								
Anesthetic Allergy								
Anemia								
Artificial Heart Valve/Joint								
Asthma								
Blood Disorder/Sickle Cell Anemia								
Cancer								
Diabetes								
Depression/Anxiety								
Heart attack/Stroke **before** 55 years old								
Hemophilia								
High Blood Pressure								
Kidney Disease								
Learning Disability/special education								
Seizures/epilepsy								
Tobacco use								
Tuberculosis/lung disease								

Please add anything about your child's health that you feel would be helpful information that has not been inquired.

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