DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Government of the District of Columbia
School Based Oral Health Program Consent Form

Dear Parent or Guardian:

The District of Columbia Department of Health (DC Health) sponsors preventive dental services at your child's school/facility through the DC School-Based Oral Health Program (SBOHP). Through this program, licensed dentists and their staff provide exams ("checkups") to students who have not seen a dentist in six (6) months. The services include dental cleanings, fluoride treatments, and sealants (as needed). Children who may need additional services such as fillings, drillings, shots, tooth removal, or braces, will be referred to their dental homes. Information from your child's visit will be shared with the appropriate point of contact at the school/facility, and with the SBOHP for the purposes of follow-up, and program monitoring.

PLEASE NOTE: Children should see their dentists every six (6) months. The SBOHP services should NOT take the place of a visit to a child's regular dentist. The dental providers will check for dental insurance coverage and the last dental visit for all children to be seen at the school/facility and will bill insurance for any services provided.

CHILD/STUDENT INFORMATION	
Child Name:	
Date of Birth (MM/DD/YY)**:**	**Current Gender Identity:**
Home Address (Street, City, State, Zip Code)**:**	
Ethnicity (check all that apply)**:** ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer	
Race (check all that apply)**:** ☐ American Indian/ Alaska Native ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Prefer not to answer	
School/Facility Name:	**Grade:**
Teacher Name:	
Parent/Guardian Name:	
Phone Number:	**Alternate Phone Number:**
Email Address:	
Last Dental Visit: ☐ 1-3 Months ago ☐ 4-6 Months ago ☐ 6+ Months go ☐ Unsure ☐ Never	
Primary Dental Provider:	

HEALTH INSURANCE

You must select one of the checkboxes and provide all related information in order for your child to receive services.

☐ **This child has the following DC Medicaid/ DC Healthy Families insurance plan:**

- ☐ **AmeriHealth Caritas (ID #: _____)**
- ☐ **Amerigroup (ID #: _____)**
- ☐ **Health Services for Children with Special Needs (HSCSN) Inc. (ID #: _____)**
- ☐ **MedStar Family Choice (ID #: _____)**
- ☐ **Medicaid Fee-For-Service ("Straight Medicaid") (ID #: _____)**
- ☐ **Other**: _____

☐ **This child has private dental insurance:**

Insurance Company: _____ Insurance Co. Phone: _____

Employer: _____ Employer Phone: _____

Name of Insured Adult: _____ Insured Adult's Date of Birth: _____

Member ID/Policy#: _____ Group #: _____

☐ **This child does not have any dental insurance**

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Please complete and sign the consent form on the back

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As the parent/guardian of the student, I consent for him/her to receive dental services through the DC Health School-Based Oral Health Program. I understand that my child's participation provides consent for the following:

- The dental provider to verify insurance before services are provided.
- The dental provider to bill & collect payment from any Medicaid, private insurance, or other payer.
- If I have private dental insurance, the dental provider to bill the family for any deductibles and/or copays.
- The dental provider to confidentially share my child's clinical information with DC Health, DC Department of Health Care Finance, Medicaid Managed Care Organizations, and/or other clinical providers involved in my child's health care.

Further, I agree to discharge, indemnify, and hold harmless the Government of the District of Columbia and any agency, employee, officer, agent, or representatives thereof from all claims, demands, actions, or judgments which I or my heirs, executors, administrators, or designees may have for any and all injuries and damages, known or unknown, caused by or arising from the activities listed above. **I understand that if I fail to sign this consent form, my child will not receive any services offered under this program.**

I understand I may revoke this consent at any time by providing written notice to DC Health's Oral Health Program (2201 Shannon Place SE, 5th Floor, Washington, DC 20020) or via email doh.oralhealth@dc.gov. I further understand that until this revocation is made, the consent for services shall remain in effect for one calendar year from the date it is signed, and my child's information will continue to be accessible by the parties listed above for the specific purposes described.

Please provide the following information to help the dental provider best serve your child:

MEDICAL INFORMATION **Check each condition that applies to your child and explain in the space provided.**
☐ **Dental problems**
☐ **Heart problems/valve replacements/shunts**
☐ **Asthma/breathing problems**
☐ **Epilepsy/seizures**
☐ **Allergies** ☐ Latex allergy ☐ Pine nut allergy ☐ Acrylic allergy ☐ Other
☐ **Current medications**
☐ **Antibiotics premedication required**
☐ **Other health problems (diabetes, bleeding problems, communicable diseases, etc.)**
Child's Primary Care Doctor and/or Provider (if applicable):

I have read the notice on the back of this page and understand and agree to its terms. By signing, I give my informed consent for my child to receive services through the DC Health School-Based Oral Health Program.

Parent/Guardian Signature: _____ **Date:** _____