CITY OF SAN ANTONIO METROPOLITAN HEALTH DISTRICT

Attachment I

DENTAL EVALUATION AND FLUORIDE VARNISH FORM

SECTION 1: TO BE COMPLETED DURING ENROLLMENT **PLEASE PRINT INFORMATION BELOW**

General Information

Child Name: _____ Child ID: _____ Head Start Center: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
PA/FSW: Name: _____ PA/FSW Phone No.: _____
Date of Birth: _____/_____/_____ Gender: ☐Male ☐Female Teacher Name/Classroom No.: _____
Child's Race/Ethnicity: ☐Hispanic ☐Non Hispanic/White ☐Black/African American ☐Multi Racial ☐Asian ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Other, specify: _____

Dental History

Does your child have dental insurance? ☐Yes ☐No If yes, name of insurance: _____
Check the appropriate box if your child has: ☐CHIP ☐Medicaid If yes, please list card no.: _____
Date of last dental visit: _____Name of dentist/dental home/clinic: _____
How often does your child visit the dentist? ☐Every 3-4 months ☐Every 6-12 months ☐Not Regularly ☐Never
Has your child ever had a cavity? ☐Yes ☐No
List any problems with your child's teeth, gums, or mouth: _____

Health History

Has your child ever had any serious health problems? ☐Yes ☐No If yes, please explain: _____
_____
Does your child have any allergies to food or medications? ☐Yes ☐No If yes, please list: _____

Consent for Participation

The information in this consent form is given so that you will be informed about the dental services your child will receive through the Head Start Oral Health Prevention Program. Services offered through the program do not take place of dental services provided through your private dentist or community clinic. San Antonio Metropolitan Health District (SAMHD) will assist families in identifying a dental home if necessary.

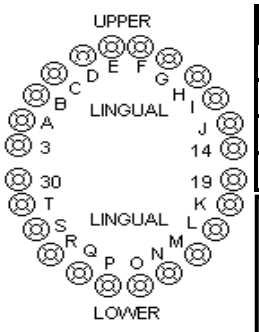
☐**Yes.** I give permission for my child to take part in the Head Start Oral Health Prevention Program, which includes a limited oral evaluation and a fluoride varnish application twice throughout the school year. I understand that a dentist from the City of San Antonio Metropolitan Health District (SAMHD) will perform a limited oral evaluation and provide me a dental referral of my child's dental status. Under the supervision of the dentist, I give permission for my child to receive an application of fluoride varnish **free of charge** provided by SAMHD. Fluoride varnish is a simple, painless dental treatment that has been proven to be effective in preventing tooth decay in children. I have been notified that my child's health information will be kept confidential and that I may review the SAMHD HIPAA policy by visiting website or may request a copy by calling 210. 207. 8841.

☐**No**. I do not want my child to take part in the Head Start Oral Health Prevention Program.

(PLEASE PRINT NAME) Parent/Guardian | _____

Parent/Guardian Signature _____ Phone **No**. _____ **Date** _____

SECTION 2: FALL DENTAL EVALUATION AND TREATMENT RECORD | THIS SECTION IS COMPLETED BY SAMHD



Fall

I certify that I have completed the services listed above

√	Services Provided	Code	Date of Service	Provider Initials
	Limited Oral Evaluation			
	Fluoride Varnish			
	Limited Oral Evaluation			
	Fluoride Varnish			

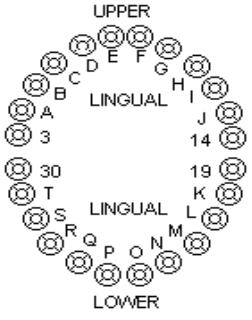
FINDINGS OF FALL EVALUATION

☐EARLY CHILDHOOD CARIES | Maxillary Arch (#C – #H)
☐CARIES EXPERIENCE | Treated or Untreated decay
☐CLASS ONE | Urgent, Needs attention immediately
☐CLASS TWO | Needs attention soon
☐CLASS THREE | No obvious signs of dental disease

ORAL HEALTH SUMMARY

☐**COMPLETE**
No treatment needed
Child has dental home

☐**NOT COMPLETE**
Treatment needed
Needs dental home



Spring

Dentist Signature: _____ **Date:** _____

SECTION 3: SPRING DENTAL EVLAUATION AND TREATMENT RECORD | THIS SECTION COMPLETED BY SAMHD

FINDINGS OF SPRING DENTAL EVALUATION

☐ Treatment appears to be completed
☐ Treatment appears to be in progress
☐ No signs that treatment has been initiated
☐ EARLY CHILDHOOD CARIES | Maxillary Arch (#C – #H)
☐ CARIES EXPERIENCE | Treated or Untreated decay

CURRENT ORAL HEALTH STATUS: ☐Class I ☐Class II ☐Class III
Progress Notes: _____
_____
_____
_____
_____

Dentist Signature: _____ **Date:** _____

CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

EVALUACIÓN DENTAL Y LA FORMA DE BARNIZ DE FLUORURO

SECCIÓN 1 (EN LETRA DE IMPRENTA) | PARA SE COMPLETADO DURANTE LA INSCRIPCIÓN

Información General

Nombre del niño: _____ Identificación del niño: _____ Head Start Center: _____
Domicilio: _____ Ciudad: _____ Estado _____Codigo Postal: _____
PA/FSW Name_____ PA/FSW Phone No: _____
Fecha de nacimiento: _____/_____/_____ Genero: ☐ Nino ☐ Nina Maestro/Nombre de clase: _____
Etnicidad/Raza del niño (seleccione): ☐Hispano ☐No-Hispano/Anglo ☐Negro/Afroamericano
☐Indio Americano/Nativo de Alaska ☐Asiático ☐Nativo de Hawaii/Islas del Pacifico ☐Multi-racial ☐Otro, especifique: _____

Historial Dental

¿Tiene su hijo seguro dental? ☐ Si ☐ No Si tiene, nombre del seguro _____
Seleccione la opción adecuado si su hijo tiene: ☐ CHIP ☐ Medicaid Incluya número de tarjeta: _____
Fecha de su última visita al dentista _____ Nombre del dentista/Clínica: _____ Teléfono: _____
¿Que tan seguido visita su hijo al dentista? ☐ Cada 3-4 meses ☐ Cada 6-12 meses ☐ Sin regularidad ☐ Nunca
¿Alguna vez tuvo su hijo caries? ☐Si ☐No
Liste cualquier problema con los dientes, encías o boca de su hijo: _____

Historial Medico

¿Ha tenido su hijo algún problema grave de salud? ☐ Si ☐ No Si ha tenido, explique: _____
_____
¿Tiene su hijo alergia a algún alimento o medicamento? ☐ Si ☐ No Por favor liste: _____

Consentimiento para Participación

La información contenida en este formulario tiene el propósito de informarle acerca del tratamiento dental que su hijo recibirá a través del programa de salud oral Head Start. Estos servicios no reemplazan los servicios dentales proporcionados por su dentista o clínica comunitaria. Si lo necesita, el San Antonio Metropolitan Health District (SAMHD) puede ayudarle a localizar una clínica dental.

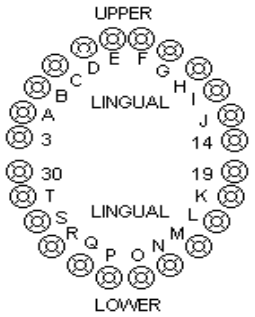
☐**Si.** Doy permiso a que mi hijo participe en el programa de Head Start Oral Prevención de la Salud, el cual incluye una evaluación dental limitada y tratamiento de barnizo de flúor dos veces por año escolar. Entiendo que un dentista de la Ciudad de San Antonio (Metropolitan Health District) llevara a cabo una evaluación dental y proporcionara una recomendación sobre el estado de salud dental de mi hijo. Doy permiso para que mi hijo reciba, bajo la supervisión de un dentista, un tratamiento de barnizo de flúor **gratuito** proporcionado por el Metropolitan Health District. El barnizo de fluor es un tratamiento dental simple y sin dolor que es efectivo para prevenir deterioro de los dientes en niños. Me han notificado que la información médica de mi hijo será mantenida en confidencia y que puedo revisar la póliza de HIPAA del Metropolitan Health District HIPAA con solo visitar la página de internet o puedo solicitar una copia llamando al 210. 207.8841.

☐**No**. No doy permiso a que mi hijo participe en el programa de Head Start Oral Prevención de la Salud

Tutor Padres (en letra de imprenta) _____

Firma del padre/tutor _____ **Teléfono** _____ **Fecha** _____

SECTION 2: EVALUATION AND TREATMENT RECORD | THIS SECTION IS COMPLETED BY SAMHD



Fall

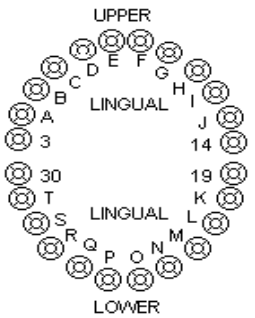
√	Services Provided	Code	Date of Service	Provider Initials
	Limited Oral Evaluation			
	Fluoride Varnish			
	Limited Oral Evaluation			
	Fluoride Varnish			

FINDINGS OF INITIAL EXAM

☐EARLY CHILDHOOD CARIES | Maxillary Arch (#C – #H)
☐CARIES EXPERIENCE | Treated or Untreated decay
☐CLASS ONE | Urgent, Needs attention immediately
☐CLASS TWO | Needs attention soon
☐CLASS THREE | No obvious signs of dental disease

ORAL HEALTH SUMMARY

☐**COMPLETE**
No treatment needed
Child has dental home
☐**NOT COMPLETE**
Treatment needed
Needs dental home



Spring

I certify that I have completed the services listed above **Dentist Signature:** _____ **Date:** _____

SECTION 3: FINDINGS OF FOLLOW-UP DENTAL ASSESSMENT | THIS SECTION COMPLETED BY SAMHD

FINDINGS OF FOLLOW UP DENTAL ASSESSMENT

☐ Treatment appears to be completed
☐ Treatment appears to be in progress
☐ No signs that treatment has been initiated
☐ EARLY CHILDHOOD CARIES | Maxillary Arch (#C – #H)
☐ CARIES EXPERIENCE | Treated or Untreated decay

CURRENT ORAL HEALTH STATUS: ☐Class I ☐Class II ☐Class III

Progress Notes: _____
_____
_____
_____
_____

Dentist Signature: _____ **Date:** _____