DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Bureau of Oral Health and Dental Services

Date: _____

School Dental Program Information Notice

Dear Parent or Guardian:

Your child has been identified as possibly being eligible to receive dental care from the Division of Public Health Dental Clinics. Eligibility is dependent on the child being enrolled in the Delaware Medicaid Program or the CHIPs program.

Besides dental services being available by an appointment made by the parent or guardian, some services can be provided to your child during school hours. These visits are made in conjunction with the school. Transportation is provided to and from the Public Health Dental Clinic.

Oral health is a very important component of overall health. Routine dental care will help your children keep their teeth in good health for years to come.

Privacy regulations (HIPAA) require the disclosure of privacy procedures for all health care services. Enclosed is a two-page letter entitled "**Notice of Privacy Practices**" that explains the privacy procedures used by the Delaware Public Health Dental Clinics, as well as some forms.

If you would like to have your child seen as part of this School Dental Program, please review this "Notice of Privacy Practices" which you may keep, then complete the three forms—"**Acknowledgement of Receipt of Notice of Privacy Practices**," the "**Medical/Dental History**," and your school's **Transportation Form,** authorizing the school to allow your child to be sent to the dental clinic—and return them to your school nurse who will make arrangements for the child to be transported to the dental clinic. *These three forms must be returned to the school nurse before the child can be sent for a dental visit.*

If you have any questions, please call your school nurse. You may also call the _____ Dental Clinic at _____ between 8:00 AM and 4:30 PM.

Sincerely yours,

DPH Dental Clinics

Division Of Public Health Dental Clinics
Medical/Dental History

Patient's Name: _____ Sex: _____ Date of Birth: _____ Age: _____

Medicaid # _____ Social Security # _____ School: _____ Grade: _____

Home Address: _____ City/town: _____ Home Phone #: _____

Parent/Guardian's Name: _____ Cell Phone # _____ Work Phone #: _____

Emergency Contact's Name: _____ Phone # _____

Physician's Name: _____ Phone # _____

Reason for Today's Visit: _____

Have you (parent/guardian) or the child had any of the following: (1) Active Tuberculosis (2) Cough with blood (3) Cough lasting longer than three weeks?
If yes, please stop and return form to receptionist

Check the box if the child has a history of or difficulty with any of the following:

☐ Anemia	☐ Cancer	☐ Fainting	☐ Immunization	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Growth Problems	☐ Kidney	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Hearing	☐ Latex Allergy	☐ Pregnancy	☐ Tuberculosis
☐ Bladder	☐ Sinusitis	☐ Heart	☐ Liver	☐ Sickle Cell	☐ Venereal Disease
☐ Bleeding Disorder	☐ Diabetes	☐ Hepatitis	☐ Mastoiditis	☐ Seizures	☐ Other _____
☐ Bones/Joints	☐ Epilepsy	☐ HIV/AIDS	☐ Measles	☐ Rheumatic fever	

Child's Medical History

	Yes	No	
Does the child currently have any illnesses?	☐	☐	If yes, what? _____
Has the child's general health changed in the past year?	☐	☐	
Is the child taking any medications at this time?	☐	☐	If yes, please list. _____
Is the child allergic to latex?	☐	☐	
Is the child allergic to any medications such as penicillin?	☐	☐	If yes, list medications. _____
Has the child ever had a serious illness?	☐	☐	If yes, what? _____
Has the child ever been hospitalized?	☐	☐	If yes, for what? _____
Does the child have any inherited conditions?	☐	☐	If yes, what condition? _____
Does the child have any speech difficulties?	☐	☐	
Has the child ever had a blood transfusion?	☐	☐	If yes, when? _____
Is the child physically, mentally, or emotionally impaired?	☐	☐	

Child's Dental History

	Yes	No		Yes	No
Is this the first visit for the child to the dentist?	☐	☐	If no, list date of last visit. _____		
Has the child had dental X-rays before?	☐	☐	If yes, when? _____		
Has the child ever suffered any injuries to the teeth/head?	☐	☐			
Has the child had any problem with dental treatment?	☐	☐	Does the child suck his thumb/finger/pacifier?	☐	☐
Has the child had problems with loss of baby teeth?	☐	☐	Has the child received orthodontic treatment?	☐	☐
Does the child take fluoride supplements?	☐	☐	Is a fluoride toothpaste used?	☐	☐

What type of water is used at home? ☐ Town supply ☐ Well water ☐ Bottled water

Toothbrushing: How many times a day? ☐ Three or more ☐ Twice ☐ Once ☐ None

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I certify that I have read and understand the above information. I also understand that incorrect or omitted health information above may pose serious consequences to my child's (my) health. I hereby give consent for the Delaware Division of Public Health to provide dental treatment necessary for my child (me). Authorization is hereby granted to proceed with examination, take appropriate x-rays, clean teeth, apply fluoride, provide oral hygiene instruction, administer local anesthetic (with needle), and any treatment deemed necessary including restorations (fillings) and extractions (tooth removal). I understand and will follow rules of the clinic including: providing current proof of Medicaid eligibility for each appointment, respecting that only patients are allowed in the treatment areas unless requested by the dentist, and that failure to show up for two scheduled appointments without prior cancellation will result in suspension of routine services for a period of six months.

Signature / Relationship to patient: _____ Date: _____

Providers' Signatures & Dates: _____

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Bureau of Oral Health and Dental Services

Notice of Privacy Practices

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice: Delaware Health & Social Services/Division of Public Health is required by law to maintain the privacy of certain confidential health care information, known as protected health information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. This notice describes your legal rights, advises you of our privacy practices, and lets you know how Delaware Health & Social Services/Division of Public Health is permitted to use and disclose PHI. Delaware Health & Social Services/Division of Public Health is also required to agree to the terms of this Notice currently in effect.

Uses and Disclosures of PHI without your authorization: Delaware Health & Social Services/Division of Public Health is permitted to use or give out PHI without your permission in certain situations, including:

- **Treatment:** We may share medical information about you to coordinate your health care. For example, we may notify your doctor about care you receive in a Public Health clinic or we may contact you to remind you of an appointment.
- **Payment:** We may use or share information about you so we properly bill and are paid. For example, sending a bill to your insurance company for payment.
- **Health Care Operations:** We may use and share information for quality assurance activities such as reviewing medical charts to ensure proper treatment was provided, licensing, training programs, obtaining legal and financial services, business planning, and processing grievances and complaints.
- **As Required By Law**: We will share information for the following:
    - Emergency situations such as a declared public health emergency;
    - To a public health authority in certain situations (such as reporting a birth, death or disease) and as part of a public health investigation to ensure proper treatment and the prevention of the spread of disease;
    - For health oversight activities, including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
    - For court order, or in some cases in response to a subpoena or other legal demand;
    - For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;
    - For military, national defense and security and other special government functions; and
    - For workers' compensation purposes, in compliance with workers' compensation laws.

Any other use or disclosure of PHI, other than those listed above, will only be made with your written authorization. An authorization specifically identifies the information we seek to use or disclose, as well as when and how we seek to use or disclose it. You may take back your authorization any time, in writing, except to the extent that we have already used or shared medical information in reliance on that authorization.

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this document.

I, _____, have received and reviewed a copy of the Delaware Health and Social Services/Division of Public Health Notice of Privacy Practices.

_____
Print name of patient (e.g. child's name) if different from above

_____
Signature of parent or guardian

_____
Date

Below is for clinic use only

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but such acknowledgement could not be obtained because (check that which applies).

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining such acknowledgement
- ☐ An emergency situation prevented obtaining such acknowledgement
- ☐ Other (specify below)

_____

_____

_____

COLONIAL SCHOOL DISTRICT

Dear Parent/Guardian,

Dental services will begin in the near future. DeLaWarr State Service Center will be caring for your child/children. Transportation will be supplied by the center also. There is no charge for this service.

Will you please fill out the form below and return it to me as soon as possible. Your child is not eligible to go to the dentist until this form and the packet is completely filled out and returned to me.

Sincerely,

School Nurse

Date_____

I hereby give my permission for my child to be transported to the dental clinic at the DeLaWarr State Service Center.

Name of child

_____

_____

Signature of Parent

_____