INSPIRE EDUCATE EMPOWER
AUBURN
City Schools

AUBURN CITY SCHOOLS DENTAL CLINIC AGREEMENT FOR TREATMENT

(Complete pages 1-6 and return to your student's school.)

The Auburn City Schools Dental Clinic is celebrating its 48th year of operation this school year. The mission of ACS Dental Clinic is to provide all qualified students with comprehensive dental care to enhance their school attendance and academic learning. To qualify for services, a student must receive free or reduced meal benefits and have no private insurance or ALL KIDS insurance. Students with Medicaid benefits are eligible. **There is no cost to parents for these dental services.**

The ACS Dental Clinic is located at J. F. Drake Middle School. Dentists and hygienists are compensated to provide dental services for ACS students. All dentists and hygienists are licensed by the State of Alabama. Most dentists have private practices in the Auburn/Opelika area.

Transportation is provided by private school vehicle or school bus, to and from J. F Drake Middle School. Students are scheduled to receive dental services without prior notification to parents. However, if a parent wishes to be notified of upcoming dental appointments, arrangements can be made with the ACS Dental Clinic Coordinator at 887-1948.

Students are supervised in the waiting room by Dental Clinic staff at all times. Before leaving the Dental Clinic, students are given a treatment letter to take home to their parents or guardian. The treatment letter explains dental services provided and future dental needs. Each student is also given a new toothbrush, toothpaste and dental floss to take home.

If the student is uncooperative with the dentist or staff, the student will not be seen and may be dismissed from the program. The parent/guardian will be notified if this occurs and action will then be determined. Should a student require more extensive treatment that can be provided, the parent/guardian will be contacted to determine if they wish for a referral to be made with another dentist. (The parent/guardian will receive prior notification if the treatment would be at the parent's expense.)

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(334) 887-2100 • FAX (334) 887-2107

AGREEMENT FOR TREATMENT

PLEASE COMPLETE THE FOLLOWING STATEMENT:

I, _____, parent or guardian of _____, give permission for my child to receive dental services such as: dental screenings, dental examinations, dental cleanings, dental sealants, dental fillings, dental extractions (w/parent's approval on permanent teeth), X-rays, local anesthetic injections and other services as indicated. I give permission for my child to be transported by a private school vehicle or bus to and from my child's dental visit.

I understand that my child's dental records are strictly confidential. I hereby authorize use of these records by all persons employed with Auburn City Schools, such as ACS Dental Staff, physicians, nurses, nutritionists, social workers and other providers participating in the provision of health related services. I release The Auburn City School System and or treatment site agencies and their health officers, employees, and agents from all liability from the use of this information.

I have received and reviewed the Auburn City Schools Notice of Privacy Practices information and I understand and agree with the terms therein. **I agree to notify the ACS Dental Clinic of any changes in my child's health history, lunch status, insurance eligibility, address and contact information.**

I authorize the following local person to be my emergency contact to receive and release information if I am unable to be reached by the contact information submitted.

_____ _____

Emergency Contact Contact Number

_____ _____

PARENT SIGNATURE **DATE**

STUDENT HEALTH HISTORY FORM

(This form must be completed annually before your child can receive free dental care at ACS Dental Clinic.)

Today's date: ____/____/____

Patient's Name: _____ Birth Date: _____ Gender: M or F

Race: _____ SS Number: _____

Address: _____ School: _____ Grade: _____

Home Phone: _____ Parent's Cell phone: _____

Parent's Work Phone: _____ Other Contact Number: _____

Physician's Name: _____ Physician's phone number: _____

Local Pharmacy use by family: _____ Pharmacy phone number: _____

Does the patient have private DENTAL Insurance? Yes or No Name of Insurer: _____

Does the patient currently have ALL Kids Insurance? Yes or No

Does the patient have Medicaid coverage? Yes or No Medicaid Number: _____

I HEREBY AUTHORIZE PAYMENT OF MEDICAID BENEFITS TO AUBURN CITY SCHOOLS DENTAL CLINIC. I ALSO AUTHORIZE THE CLINIC TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF THE EXAMINATION OR TREATMENT, SO THAT INSURANCE BENEFITS OR OTHER PAYMENTS MAY BE PROMPTLY AND CORRECTLY FILED. I FURTHER AUTHORIZE THE USE AND/OR COPYING OF SUCH RECORDS FOR PURPOSES OF AUDIT. I ALSO UNDERSTAND MY CHILD'S SOCIAL SECURITY NUMBER WILL BE USED FOR IDENTIFICATION PURPOSES ONLY.

_____ _____

PARENT SIGNATURE **DATE**

STUDENT / PATIENT MEDICAL HISTORY

Is the patient currently being treated by a physician for any medical problems? Yes or No
(If yes, please explain: _____)

Has the patient been hospitalized, had any surgeries, or been to the ER for any tooth/mouth related problems?
Yes or No (If yes, please explain: _____)

Is the patient taking any medications? Yes or No

(If yes, Name: _____ Dose: _____ Reason: _____
Name: _____ Dose: _____ Reason: _____
Name: _____ Dose: _____ Reason: _____

Does the dentist have your permission to administer a pain reliever (such as Tylenol) following a procedure? Yes or No

Does the patient have any allergies? Yes or No Latex Allergies? Yes or No

(If yes, please list: _____)

Does the patient have any of the following?

ADD/ADHD	YES	NO
Aids/HIV Positive	YES	NO
Anemia	YES	NO
Asthma	YES	NO
Autism	YES	NO
Bleeding Disorder	YES	NO
Bone Disorder	YES	NO
Cancer/Tumors	YES	NO
Diabetes	YES	NO
Endocrine Disorder	YES	NO
Gastric Reflux	YES	NO
Heart Defects	YES	NO
Heart Disease	YES	NO
Hemophilia	YES	NO
Hepatitis	YES	NO
Kidney Disorder	YES	NO
Liver Disorder	YES	NO
Lung Disorder	YES	NO
Mental Disability	YES	NO
Muscle Disorder	YES	NO
Pregnancy	YES	NO
Rheumatic Fever	YES	NO
Seizures/ Epilepsy	YES	NO
Sickle Cell Anemia	YES	NO
Sleep Apnea	YES	NO
Tobacco Use	YES	NO
Tuberculosis	YES	NO

If YES on any, please elaborate:

_____

_____

**** IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO REPORT ANY SIGNIFICANT CHANGES IN THEIR CHILD'S MEDICAL CONDITION DURING THE SCHOOL YEAR.**

_____ _____ _____

PRINT: Parent or Guardian **SIGNATURE** : Parent or Guardian **DATE:**

AUBURN CITY SCHOOLS DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Auburn City Schools protects the privacy of your student's health information. For some activities, we must have your written authorization for us to disclose your student's dental information. This protected health information may concern the student's medical status, medical condition, prognosis, diagnosis and related individual identifiable health information.

This protected health information may be released to one or more of the following:

- **Other health care provider**
- **Hospitals**
- **Medical clinics**
- **Medicaid**
- **Medical insurance coordinators**
- **School Administrators**
- **All persons in the Auburn City Schools, such as physicians, nurses, nutritionists, social workers, and other providers participating in the provision of health related services.**

Therefore I, _____parent/guardian of _____ (the student) hereby authorize dentists, hygienists, and other medical staff representing Auburn City Schools to release information regarding the student's protected health information.

I understand that as a parent/ legal guardian, my authorization/consent to the disclosure of the student's protected health information is a condition for the student's participation in the Auburn City Schools' health related services. I understand the student's protected health information is protected under federal law. I, the parent/legal guardian, understand that once the information is disclosed per this authorization, the information is subject to re-disclosure by the recipient and no longer be protected by federal law. I, the parent/legal guardian, understand that I may refuse to sign this authorization, but if I do, Auburn City Schools will not allow the student to participate in the Dental Clinic or utilize services of the school nurse. I may revoke this authorization at any time by notifying Auburn City Schools Privacy Officer in writing, but if I do, it will not have any effect on the actions taken in reliance of my prior authorization. This authorization will be effective for the duration of the time the child is enrolled in the Auburn City Schools.

I acknowledge that I have received Auburn City Schools Privacy Practice.

_____ _____

Parent/Legal Guardian's Signature **Date**