

Cincinnati Health Department

School-Based Health Center Enrollment Packet

For students at NON-SBHC schools

PLEASE COMPLETE AND SIGN ALL PAGES.

STUDENT/PATIENT'S NAME: _____ DOB: ___/___/___ Gender: M/F Trans: MTF/FTM or Non-Binary

Child's Social Security #: _____ - _____ - _____ Medical Card/Insurance ID: _____

CareSource Molina Buckeye Paramount United Health Care No Insurance OTHER _____

DENTAL HEALTH CARE SERVICES:



YES, I consent for my child to receive **DENTAL SERVICES** at a Cincinnati Health Department (CHD) Center or school-based/mobile clinic including preventive care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals if necessary. Sealants and other preventive procedures will be provided at school. My child may be **TRANSPORTED/ACCOMPANIED** to and from dental services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

NO, I do not wish for my child to receive **DENTAL SERVICES**

EYE CENTER SERVICES:



YES, I consent for my child to receive **EYE CENTER SERVICES** at the OneSight Vision Center at Oyler School or Academy of World Languages, which may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction. My child may be **TRANSPORTED/ACCOMPANIED** to and from eye center services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

NO, I do not wish for my child to receive **VISION SERVICES**

MEDICAL HEALTH CARE SERVICES: Available at the following sites: Aiken, AWL, Children's Home of Cinti, JP Parker, Mt. Airy, Oyler, Riverview, Roberts, Roll Hill, Ethel Taylor, Taft HS, West Hi/Dater HS, and Withrow HS)



YES, I consent for my child to receive **MEDICAL CARE** including routine well childcare* (e.g. work, daycare, and sports physicals) appropriate immunizations, fluoride varnish and treatment for illness or injury including over the counter medications unless emergency services are needed. (*Note: well child care includes vision/hearing screening, urine and blood tests, immunizations as needed, and an external genital exam when appropriate).

***Please note: in Ohio, minors may access confidential service for sexually transmitted infections and family planning, including provision of contraception such as condoms or birth control pills without parental consent.**

NO, I do not wish for my child to receive **MEDICAL CARE** at the school-based health center (SBHC)



Parent / Guardian Signature (or patient if 18 or older) Parent/Guardian Name (PRINT) DATE

Phone (best) _____ Phone #2 _____ Phone #3 _____

ADDRESS STREET APT CITY STATE ZIP

I give consent for my child to obtain the services that I have marked in the boxes above. I agree to the terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in Program Description form (attached). Consent in effect until terminated in writing by Parent/Guardian.

STUDENT/PATIENT'S NAME: _____ DOB: ___/___/___

To provide health services for your child we need the following information:

Parent/Guardian Name: _____ Parent/Guardian's Date of Birth: _____

Relationship to Child: _____ Parent/Guardian's Social Security No.: _____

Address: _____ City/State/ZIP: _____

Emergency Contact Person: _____ Phone Number: _____

Your Child's Health History

❖ Do you have a **Primary Care Doctor**? YES NO

Doctor Name/Clinic: _____ Phone #: _____ Fax #: _____

Date of last complete yearly physical examination (head to toe): _____

❖ Do you have a **Primary Dentist**? YES NO

Dentist Name/Clinic: _____ Phone #: _____ Fax #: _____

Date of last routine dental check-up: _____

❖ Do you have a **Primary Eye Doctor**? YES NO

Eye Doctor Name: _____ Phone #: _____ Fax #: _____

Date of last routine vision exam: _____

❖ Do you have a **Preferred Pharmacy**? YES NO

Preferred **Pharmacy**: _____ Phone #: _____ Fax #: _____

Please list any **CURRENT** health problems or conditions your child has:

Please list any **allergies** (include **food, medications**, environmental, seasonal, etc.):

Does your child see a specialist? If yes, please list condition, doctor's name, and phone number:

Please list any medications (prescribed or over-the-counter) your child takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches):

****SPECIAL NOTE: If your student needs to take any medications at school, including emergency medications (like an inhaler or Epi Pen), you must complete a CPS Administration of Medication form****

Has your child had any operations, serious injuries, or hospitalizations? No Yes

Please provide reason and dates: _____

Has your child ever been pregnant? No Yes If Yes, how many living children has your child given birth to: _____

Has your child been a victim of abuse? No Yes

Has anything bad, scary or sad happened to your family? No Yes

Please explain: _____

School Concerns: Explain any YES answers on the line provided.

Is your child in a special class (Special Ed / IEP / 504 Plan)? YES NO _____

Has your child repeated a grade? YES NO _____

Does your child get into trouble often at school? YES NO _____

What are your child's grades? _____ **Is this a change?** YES NO

Consent for Nitrous Oxide Sedation

Patient Name: _____

If your child needs dental treatment, it may be beneficial or necessary to use nitrous oxide sedation in order to complete the dental treatment. Nitrous oxide relaxes children, makes them more comfortable, and gives them an all-around better experience at their dental appointment. By signing this form ahead of time it will be easier for us to do the treatment in a more timely and efficient manner. We will attempt to call you prior to using nitrous oxide on your child. Please read the following and sign at the bottom if you consent to treatment with nitrous oxide sedation. It will only be used if necessary.

I give permission for a Cincinnati Health Department dentist to give my child nitrous oxide sedation if indicated. I understand that some side effects could occur including:

1. Nausea and vomiting – we suggest that no food be eaten for at least two hours before the appointment.
2. Excessive sweating and patient may get red or flushed.
3. An unusually high amount of saliva is sometimes produced.
4. Although not common, a patient may get a sensation of having the chills.
5. In unusual circumstances, a child may become temporarily hyperactive.

The benefits include relaxation and possibly eliminating the need for local anesthetic injections (“Novocaine”). For those patients who may need both, the use of nitrous oxide/oxygen will make the injections much easier for the patient.

At no time will the patient be “asleep” and at all times the patient will be given more oxygen than what is present in room air. Patients will be monitored continually by the dentist and staff, and a parent can be present as well if requested.

If you would like to be present, please make a note on the top of this form and we will be happy to schedule an appointment for you at your convenience.

I consent for my child to receive nitrous oxide sedation as deemed necessary by the dentist. I understand the dental staff will attempt to contact me prior to administering nitrous oxide.

I do not consent for my child to receive nitrous oxide sedation.



Signature (Parent/Guardian)

Phone Number

Date

PLEASE REVIEW THE FOLLOWING INFORMATION

Program Description
School-Based Health Center
Cincinnati Health Department

Welcome to the School-Based Health Center. The School-Based Health Center makes medical, dental and vision care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center. If your child/adolescent develops a dental problem at school, a dentist can see your child at one of school-based dental centers located at Academy of World Languages, Withrow High School, Western Hills High School, Oylar School, Crest Smiles Shoppe, or other CHD Health Centers. If you have any questions or need help with the application, please call the School Health Program 357-2809 or contact your school nurse

Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex; or sexual orientation.
- To have a health care assessment and plan of care and participate in your health care plan.
- To talk to your health care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow 30 days for completion of insurance or disability forms..
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency call 911 or go to the nearest emergency room. If you have an urgent issue and would like to speak with the provider on call, please call 357-7320.


Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Cincinnati Health Department sliding fee scale. This information will be kept strictly confidential.
- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid, you can stop by our center or call 513-357-2787.

Regarding the SHARING OF HEALTH INFORMATION:

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's regular doctor/clinic.
- The PHHC, School-Based Health Center and/or the Cincinnati Health Department (CHD) school nurse will share medical information with each other as needed.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or a community site. The mental health provider will contact you for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.
- Dates of service regarding completed dental, vision and medical care (ie. Immunizations, annual well-child check and asthma care) may be shared with your child's school if you agree and sign the Authorization form provided with this consent.

I have the right to receive or review a copy of the Notice of Privacy Practices. I acknowledge that I have been offered a copy of the Notice of Privacy Practices:

 I have received or reviewed a copy (signature and date) _____

I do not want a copy (signature and date) _____

I authorize the SBHC to call my home or cell phone number and leave a message with an adult that answers the telephone or on the voicemail pertaining to my child's medical care, including laboratory results.

INFORMED CONSENT FOR SILVER DIAMINE FLUORIDE

Silver diamine fluoride (SDF) is an antimicrobial liquid used to treat tooth sensitivity and to help stop tooth decay. Reapplication of SDF may be necessary to better control caries progression and is recommended every 3, 6 or 12 months but may be applied more frequently if needed. Treatment with SDF may not eliminate the need for dental fillings or crowns to repair function or esthetics. Additional procedures may incur a separate fee.

Facts for consideration:

- The procedure involves: 1) Proper isolation of the area and drying of affected teeth. 2) Rub a small amount of SDF on the decayed area. 3) Allow SDF to act on the tooth surface for at least 1 min, preferably up to 4 minutes. 4) Rinse tongue and oral mucosa.
- I should not be treated with SDF if: 1) I am allergic to silver or ammonia. 2) There are painful sores or raw areas on my gums or anywhere in my mouth (i.e., ulcerative gingivitis, gingivostomatitis).

Benefits of SDF treatment:

- It is quick, easy and painless.
- No need to numb teeth.
- It arrests 80% of cavities when applied twice yearly.
- It can help relieve tooth sensitivity.
- It is a temporary treatment option for young, fearful, or special needs that may require sedation for extensive dental care.



patients

Risks related to SDF:

- **The affected area will stain black permanently.** Healthy tooth structure will not discolor. Stained tooth structure can be covered with a filling or a crown in the future.
- If accidentally applied to the skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off, and it will disappear in a few days to 2 weeks.
- You may notice a very temporary metallic aftertaste.
- SDF may not work for all cavities and decay will progress with poor oral hygiene and food impaction. In that case, the affected tooth will require further treatment, which can involve a filling or a crown, root canal therapy, extraction, or referral for specialty dental care.

Alternatives to SDF, not limited to the following:

- No treatment, which may lead to progression of cavities, severe pain and more serious dental infection.
- Depending on the location and extend of the tooth decay as well as the level of patient behavior and cooperation, other treatment may include fluoride varnish, a filling or crown, extraction, or referral to a specialist.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner. I have seen the photo displaying the discoloration of the cavity after SDF application. I consent to have Silver Diamine Fluoride (SDF) treatment with a dentist or another qualified dental staff at any dental site operated by the Cincinnati Health Department.

Patient Name: _____

Date of Birth: _____

Patient/Guardian Signature: _____

Date: _____

CHD Dental Staff Signature: _____

Date: _____