Salud Family Health Centers SMILES Consent
Sherman Permission Form

Sherman and Salud Family Health Centers will be providing preventative dental services throughout the school year**. All children are eligible** to receive these dental services regardless of their dental insurance/Medicaid. If the child has Medicaid, CHP+, or Delta Dental insurance Salud will bill these programs for services provided. Salud is waiving the copays for these services due to the burden of collecting copays from children in a school setting. **Families will not be billed for these services.** As a health center, we are required to ask about income levels. All information is confidential. Children will have their teeth and gums checked for potential problems and parents will be informed if a child has any cavities or needs further treatment by a dentist.

When electing to participate in this program, your child will be seen at his/her school by a Registered Dental Hygienist. The dental hygienist may provide some or all of the services listed below and communicate with a dentist through a computer about your child's teeth and gums. The dentist will review the information gathered by the dental hygienist (x-rays, dental history, photos, etc.) and will develop a recommended treatment plan.

I give permission for the dental hygienist to provide some or all of the following services for my child:* ☐ Yes ☐ No
**Due to COVID-19 outbreak, some services listed below will be postponed until 2021*

- Complete Dental Exam
- X-rays
- Teeth Cleaning
- Pictures of his/her teeth
- Fluoride treatment
- Sealants

Does your child have allergies or any medical conditions? ☐ Yes ☐ No
Please explain if answered Yes: _____

If your child needs extensive treatment that can only be done at a dental office, your child will need to be seen at the Salud Family Health Centers clinic or by your regular family/pediatric dentist.

A copy of Salud's Notice of Privacy Practices is attached hereto and can be found at http://www.saludclinic.org/. This document informs patients about how their protected health information will be shared or kept confidential. I certify that I have read (or had read to me) the contents of this form and that I have access to Salud's Notice of Privacy Practices. I understand that if I need further information or if I have any questions that I can contact **SMILES Project Navigator at 970-441-6049.** I understand that my child's screening results may be shared with their school's health assistant/health paraprofessional. I believe that I have been given sufficient information to give my consent.

Parent/Guardian Signature: _____Date:_____

School: _____ Grade: _____ Teacher: _____

"Salud is a federally qualified health center whose mission is to provide a quality, integrated health care home to the communities we serve. As part of our federal grant requirements, we need to collect all of the information below."

Child's Last Name:	**Child's First Name:**	**Email Address:**
Date of Birth:	**Age:**	**Gender:** ☐ Male ☐ Female
Parent/Guardian Name:	**Parent/Guardian DOB*Relationship to Patient:**	**Home Phone:**
Address:	**City, State, Zip:**	**Cell Phone:**
Household size: _____ **Ethnicity:** ☐ Hispanic ☐ Latino **Race:** ☐ Asian ☐ White ☐ Native Hawaiian ☐ Black or African American ☐ American Indian ☐ Other	**Total Estimated Income:** _____ ☐ Monthly ☐ Annual **Does your family live in public housing?** ☐ Yes ☐ No **Is your family currently homeless?** ☐ Yes ☐ No **Is anyone in your family a migrant or seasonal farmworker?** ☐ Yes ☐ No **Primary Language:** ☐ English ☐ Spanish ☐ Other _____	
Type of dental insurance? ☐ CHP+ ☐ Private Insurance ☐ Medicaid ☐ None **Subscriber number :**		
Has your child seen a dentist before: ☐ No ☐ Yes - date of last apt_____ with DR. _____		