DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Government of the District of Columbia
School Based Oral Health Program Consent Form

Dear Parent or Guardian:

The District of Columbia Department of Health (DC Health) sponsors preventive dental services at your child's school/facility through the DC School-Based Oral Health Program (SBOHP). Through this program, licensed dentists and their staff provide exams ("checkups") and x-rays to students who have not seen a dentist in six (6) months. The services include dental cleanings, fluoride treatments, and sealants (as needed). Children who may need additional services such as fillings, drillings, shots, tooth removal, or braces, will be referred to their dental homes. Information from your child's visit will be shared with the appropriate point of contact at the school/facility, and with the SBOHP for the purposes of follow-up, and program monitoring.

PLEASE NOTE: Children should see their dentists every six (6) months. The SBOHP services should NOT take the place of a visit to a child's regular dentist. The dental providers will check for dental insurance coverage and the last dental visit for all children to be seen at the school/facility and will bill insurance for any services provided.

CHILD/STUDENT INFORMATION	
Child Name: Click or tap here to enter text.	
Date of Birth (MM/DD/YY)**:** Click or tap here to enter text.	**Current Gender Identity:** Click or tap here to enter text.
Home Address (Street, City, State, Zip Code)**:** Click or tap here to enter text.	
School/Facility Name: Click or tap here to enter text.	**Grade:**
Teacher Name: Click or tap here to enter text.	
Parent/Guardian Name: Click or tap here to enter text.	
Phone Number: Click or tap here to enter text.	**Alternate Phone Number:** Click or tap here to enter text.
Email Address: Click or tap here to enter text.	
Last Dental Visit: ☐ 1-3 Months ago ☐ 4-6 Months ago ☐ 6+ Months ago ☐ Unsure ☐ Never	
Primary Dental Provider: Click or tap here to enter text.	

HEALTH INSURANCE

You must select one of the checkboxes and provide all related information in order for your child to receive services.

☐ **This child has the following Medicaid/Health Families insurance plan:**

☐ DC Healthy Families ☐ DC Medicaid ☐ AmeriHealth Caritas ☐ MedStar Family Choice ☐ CareFirst
☐ Health Services for Children with Special Needs ☐ Other: _____

☐ Medicaid/DC Healthy Families #: _____

☐ **This child has private dental insurance:**

Insurance Company: Click or tap here to enter text. Insurance Co. Phone:
Employer: Click or tap here to enter text. Employer Phone:
Name of Insured Adult: Click or tap here to enter text. Insured Adult's Date of Birth:
Member ID/Policy#: Click or tap here to enter text. Group #: Click or tap here to enter text.

☐ **This child does not have any dental insurance**

Please complete and sign the consent form on the back

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As the parent/guardian of the above-named student, I consent for him/her to receive dental services through the DC Health School-Based Oral Health Program. I understand that my child's participation provides consent for the following:

- The dental provider to verify insurance before services are provided.
- The dental provider to bill & collect payment from any Medicaid, private insurance, or other payer.
- If I have private dental insurance, the dental provider to bill the family for any deductibles and/or copays.
- The dental provider to confidentially share my child's clinical information with DC Health, DC Department of Health Care Finance, Medicaid Managed Care Organizations, and/or other clinical providers involved in my child's health care.

Further, I agree to discharge, indemnify, and hold harmless the Government of the District of Columbia and any agency, employee, officer, agent or representatives thereof from all claims, demands, actions, or judgments which I or my heirs, executors, administrators, or designees may have for any and all injuries and damages, known or unknown, caused by or arising from the activities listed above. **I understand that if I fail to sign this consent form, my child will not receive any services offered under this program.**

I understand I may revoke this consent at any time by providing written notice to DC Health's Oral Health Program (899 N. Capitol St. NE, 3rd Floor, Washington, DC 20002) or via email hcab.dchealth@dc.gov. I further understand that until this revocation is made, the consent for services shall remain in effect for one calendar year from the date it is signed, and my child's information will continue to be accessible by the parties listed above for the specific purposes described.

Please provide the following information to help the dental provider best serve your child:

MEDICAL INFORMATION **Check each condition that applies to your child and explain in the space provided.**
☐ **Dental problems** Click or tap here to enter text.
☐ **Heart problems/valve replacements/shunts** Click or tap here to enter text.
☐ **Asthma/breathing problems** Click or tap here to enter text.
☐ **Epilepsy/seizures** Click or tap here to enter text.
☐ **Allergies** ☐ Latex allergy ☐ Pine nut allergy ☐ Acrylic allergy ☐ Other Click or tap here to enter text.
☐ **Current medications** Click or tap here to enter text.
☐ **Antibiotics premedication required** Click or tap here to enter text.
☐ **Other health problems (diabetes, bleeding problems, communicable diseases, etc.)** Click or tap here to enter text.
Child's Primary Care Doctor and/or Provider (if applicable): Click or tap here to enter text.

I have read the notice on the back of this page and understand and agree to its terms. By signing, I give my informed consent for my child to receive services through the DC Health School-Based Oral Health Program.

Parent/Guardian Signature: _____ **Date:** _____

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GOVERNMENT OF THE DISTRICT OF COLUMBIA

Oral Health Assessment Form

For all students aged 3 years and older, use this form to report their oral health status to their school/childcare facility.

Instructions

- Complete Part 1 below. Take this form to the child/student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/childcare facility.

Part 1: Child/Student Information (To be completed by parent/guardian)

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Student ID _____ Date of Birth (MMDDYYYY): ☐☐/☐☐/☐☐☐☐

Current Gender Identity: _____

Home Address: _____ Home State: ____ Home Zip Code ☐☐☐☐☐

School Grade	Day-care	Pre-K3	Pre-K4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Part 2: Child/Student's Oral Health Status (To be completed by the dental provider)

	Yes	No
1. Does the patient have at least one tooth with **apparent cavitation** (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	☐	☐
2. Does the patient have at least one **treated carious tooth**? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	☐	☐
3. Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
4. Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
5. Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

6. How many **primary teeth** in the patient's mouth are affected by caries that are either:
   - **a. Untreated** ☐☐
   - **b. Treated with fillings/crowns?** ☐☐
7. How many **permanent teeth** in the patient's mouth are affected by caries that are either:
   - **a. Untreated** ☐☐
   - **b. Treated with fillings/crowns** ☐☐
   - **c. Extracted due to caries?** ☐☐
8. What type of dental insurance does the patient have? Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____ Dental Office Stamp

Dental Provider Signature _____

Dental Examination Date _____

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and childcare centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.

DC HEALTH School Immunization Requirements Guide

All students attending school in DC must present proof of appropriately spaced immunizations by the first day of school. Please complete and return your student's school health forms including the Universal Health Certificate and Oral Health Assessment Form.

ALL STUDENTS SHOULD RECEIVE AN ANNUAL FLU VACCINE

ELIGIBLE STUDENTS SHOULD RECEIVE TWO DOSES OF COVID-19 VACCINE UPON MANDATE

My student should receive these vaccine doses upon school enrollment*

2-3 years old

Preschool to Head Start

The following vaccines are typically received before the age of 2:

4 doses of Diphtheria/Tetanus/Pertussis (DTaP)

3 doses of Polio

1 dose Varicella if no history of chickenpox

1 dose of Measles/Mumps/Rubella (MMR)

3 doses of Hepatitis B

2 doses of Hepatitis A

3 or 4 doses depending on the brand of Hib (Haemophilus Influenza Type B)

4 doses of PCV (Pneumococcal)

4-6 years old

Kindergarten to 1st Grade

Additional doses needed after receiving the vaccines listed above:

1 dose of Diphtheria/Tetanus/Pertussis (DTaP)

1 dose of Polio

1 dose of Varicella if no history of chickenpox

1 dose of Measles/Mumps/Rubella (MMR)

7-10 years old

2nd Grade to 5th Grade

Consult your doctor and make sure your student received all the vaccines listed above!

11+ years old

6th Grade to High School

Additional vaccines needed after receiving all vaccine doses listed above: 1 dose of Tdap

2 doses of Meningococcal (Men ACWY)

2 or 3 doses of Human Papillomavirus Vaccine (HPV)

*The spacing and number of doses required may vary. Please contact your child's health care provider. For additional information, contact DC Health's Immunization Program at (202) 576-7130.

DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ☐ Male ☐ Female ☐ Non-Binary	
Home Address:	**Apt:** / **City:** / **State:** / **ZIP:**	
Ethnicity: *(check all that apply)*	☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer	
Race: *(check all that apply)*	☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer	
Parent/Guardian Name:	**Parent/Guardian Phone:**	
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ☐ Medicaid ☐ Private ☐ None	**Insurance Name/ID #:**	
Has the child seen a dentist/dental provider within the last year? ☐ Yes ☐ No		

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year.

Parent/Guardian Signature:_____ **Date:**_____

Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	**BP:** ___/___ ☐ NML ☐ ABNL	**Weight:** ☐ LB ☐ KG	**Height:** ☐ IN ☐ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ☐ Corrected ☐ Uncorrected ☐ Wears glasses ☐ Referred ☐ Not tested

Hearing Screening: *(check all that apply)* ☐ Pass ☐ Fail ☐ Not tested ☐ Uses Device ☐ Referred

Does the child have any of the following health concerns? *(check all that apply and provide details below)*

- ☐ Asthma
- ☐ Autism
- ☐ Behavioral
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Developmental
- ☐ Diabetes
- ☐ Failure to thrive
- ☐ Heart failure
- ☐ Kidney failure
- ☐ Language/Speech
- ☐ Obesity
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sickle cell
- ☐ Long term COVID-19 symptoms
- ☐ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ☐ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ☐ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ☐ **Other:**_____

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note._____

_____

TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.

What is the child's risk level for TB?

- ☐ High → *complete skin test and/or Quantiferon test*
- ☐ Low

Skin Test Date:			**Quantiferon Test Date:**	
Skin Test Results:	☐ Negative	☐ Positive, CXR Negative	☐ Positive, CXR Positive	☐ Positive, Treated
Quantiferon Results:	☐ Negative	☐ Positive	☐ Positive, Treated	

Additional notes on TB test:

Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or fax 202-535-2607.

ONLY FOR CHILDREN UNDER AGE 6 YEARS *Every child must have 2 lead tests by age 2*	**1st Test Date:**	**1st Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**2nd Serum/Finger Stick Lead Level:**
HGB/HCT Test Date:		**HGB/HCT Result:**	

Part 3: Immunization Information | To be completed by licensed health care provider.

Child Last Name:	Child First Name:	Date of Birth:

Immunizations	In the boxes below, provide the dates of immunization (MM/DD/YY)						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month & year): Verified by:_____ (name & title)				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Coronavirus (COVID) (Recommended)	1	2					
Other	1	2	3	4	5	6	7

☐ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:**_____

Medical Exemption (if applicable)

I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles

☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Is this medical contraindication permanent or temporary? ☐ Permanent ☐ Temporary until:_____(date)

Alternative Proof of Immunity (if applicable)

I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles

☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. ☐ No ☐ Yes

This child is cleared for **competitive sports.** ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance from: _____

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp	Provider Name:	
	Provider Phone:	
	Provider Signature:	Date:

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:	Signature:	Date:
Health Suite Personnel Name:	Signature:	Date: