CONSENT & INFO PACKET for the UKNFVCHC Mobile Dental Outreach Program

The UK North Fork Valley Community Health Center's **MOBILE DENTAL** program has been serving the children in Eastern Kentucky for **15 years**. We are thankful that you have entrusted us with the dental care of your children for many years, and we want to assure you that we are making changes and going

ABOVE and BEYOND to ensure your child's continued SAFETY

and comfort on-board the mobile dental units this upcoming school year. We know that the COVID-19 pandemic is a scary time for everyone, and we would like for you to know what our NEW protocols will be.

If you have any questions, please call us at (606) 785-3175 or text either 216-0261 or 438-3551.

NEW for dental staff:	All dental staff will have a medical screening before each shift and will not work if sick.
	Only 2 dental staff will work on-board the mobile unit each day to help with maintaining 6 feet of social distancing.
NEW for children:	All children will have their forehead temperature taken by the dental staff before coming on-board the mobile unit and will not be seen that day if sick.
	Only 2 children will be brought to the mobile unit at a time to help maintain 6 feet of social distancing.
	Children will wear their mask on the way walking to the mobile unit and while waiting their turn on-board.
	Each child will be seen in an individual area on the mobile unit and will maintain 6 feet of social distancing from other children. One child will be in each dental chair and one child will be waiting.
NEW air filtration processes:	Per the state recommendations, we have purchased the best hospital grade HEPA air filters on the market, and have installed one right next to each dental chair. These are capable of cleaning the air on the entire mobile unit every 15 minutes, and can filter down to a particle size smaller than the corona virus.
	Per the CDC recommendations, while the pandemic is in effect, we will continue to avoid all "aerosol generating procedures."
SAME excellent dental care:	Dental staff will continue to wear full PPE (personal protective equipment) including gowns, gloves, and surgical masks.
	Dental staff will continue to practice diligent hand hygiene, and will also make hand sanitizer and tissues available to children.
	Dental staff will continue to practice the same exceptional cleaning and sterilization procedures we have always followed, including use of a hospital-grade disinfectant cleaner, disposable plastic barriers to cover surfaces, and single-use disposable items on each child to avoid spreading germs. Toothbrushes are placed in sealed zip-bags for safety.
NEW for parents choosing the N.T.I. option:	**Our services are still available to children who will be doing school at home this year!!** Please call us and we will schedule a time to see your child while we are parked at your school (NTI kids will be seen on the mobile unit either after school hours or on days when school is not in session). Or call us and we will schedule an appointment at our dental clinic in Hazard. **Call 606-785-3175 or 606-439-1559** to let us know your plans!

DENTAL OUTREACH PROGRAM

Consent Packet

Dear Parent/Guardian:

The "**Ronald McDonald Care Mobile"** or the **"Mountains of Smiles Dental Mobile"** and the UK North Fork Valley Community Health Center's Dental Outreach Team will visit your child's school or Head Start center this year to provide a FREE dental care program which includes DIFFERENT OPTIONS this year for you to choose from:

√		**OPTIONS AVAILABLE FOR IN-PERSON STUDENTS AT SCHOOL:**
	OPTION 1	DENTAL EXAM, CLEANING, SEALANTS AT SCHOOL ON MOBILE
	OPTION 2	LIQUID VITAMIN THAT STOPS TOOTH DECAY (SDF)
	OPTION 3	BUS RIDE TO HAZARD DENTAL CLINIC FOR FILLINGS, ETC. (PERRY STUDENTS ONLY)
If you are choosing the normal IN-PERSON SCHOOL, please fill out this whole packet and turn in to your child's teacher as usual.		

√		**OPTIONS AVAILABLE FOR N.T.I. STUDENTS STAYING HOME:**
	OPTION 1	SCHEDULED APPOINTMENT AT SCHOOL ON MOBILE AFTER NORMAL SCHOOL HOURS
	OPTION 2	SCHEDULED APPOINTMENT AT OUR HAZARD DENTAL CLINIC
If you are choosing the N.T.I. OPTION to do school at HOME, please call us as soon as possible to let us know your choice and keep this consent packet. Please call 606-785-3175 or 606-439-1559 and ask for program manager Pam Cornett.		

NEW TELE-DENTISTRY OPTION FOR ALL FAMILIES **This service is available at ANY TIME your child is having PAIN or DENTAL PROBLEMS!** **You can CALL or TEXT one of our tele-dentistry cell phones:**	
In Perry County or for LKLP Head Start, call or text 606-438-3551. Dr. Nikki Stone will take care of your child via tele-dentistry over the phone.	**In Knott or Letcher Counties, call or text 606-216-0261. Dr. Sherry Slone will take care of your child via tele-dentistry over the phone.**

If your child has a dental home already established (already has had 2 cleanings per year and all cavities filled) then you do not need to sign up for this program. Your dental insurance will be billed and it may prevent services from being covered if you have another dental home. If you have any questions about this program or the options, please call our Program Manager Pam Cornett at 606-785-3175.

OPTION 1: Informed CONSENT for Preventive Dental Care

Child's Full Name:		Child's Sex (circle):	Male or Female
911 Address:		Child's Birthdate:	_____/_____/________
Mailing Address:		Child's Social Security:	#______-_____-________
City/State/Zip:		HOME phone:	
MOM CELL phone:		WORK phone:	
DAD CELL phone:		OTHER phone:	
ETHNICITY (circle):	White, Black, Hispanic, American Indian/Native American, Asian, Arabic/Middle Eastern, East Indian, Pacific Islander, Mixed, Other:		

DENTAL INSURANCE:

(CIRCLE one and provide additional information.)

Medicaid/KCHIP Card	NO Dental Insurance	Private Dental Insurance
Name of Company:_________ #:________________	Reason__________________	(*Sorry, we cannot treat children with private dental insurance, but feel free to call & schedule in our dental office.)

__**YES,** I give permission for my child, if eligible, to be examined and treated by the University of Kentucky dental staff.

1. I understand that with Option 1 my child may receive an **exam, cleaning, fluoride and dental sealants** and that more treatment than indicated may be needed pending the results of x-rays. I understand that I may still need to take my child to a dental office to have x-rays and complete all treatment. I understand that by choosing Option 2, my child may receive a liquid vitamin to stop tooth decay. I understand that by choosing Option 3, my child may ride a school bus to the UK dental clinic in Hazard for comprehensive dental treatment including x-rays, local anesthesia, fillings, simple extractions, crowns, and/or laughing gas if needed. ***My signature below ensures my child will receive Option 1. If I choose Options 2 and/or 3, my signature is required on the following pages in this packet.***
2. I understand that this program will be provided by the dental faculty, residents, hygienists and staff of the University of Kentucky and that a University dentist faculty member (in Hazard) will direct the program.
3. I understand that the preventive treatment (cleaning/fluoride/sealants) may be provided by the dental hygienist without the dentist, under general supervision after the dentist has done the exam.

__**YES,** I understand that the dental findings for all the children as a group may be reported on and/or published, and that, in this case, **no child will be identified individually**. While all the individual dental records are held by the University of Kentucky as confidential, I understand that a list of children who need follow-up dental treatment is routinely provided to the Head Start or school family resource staff.

__**YES,** I give permission for my child to be **photographed/videotaped** by the University of Kentucky newspapers and/or other print and television media for educational, informational and promotional use.

CONSENT TO TREATMENT: I authorize the rendering of diagnostic and treatment procedures by authorized agents and employees of the University of Kentucky, and the dental staff, or their designees, as may in their professional judgment be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. Further, I authorize the use of my patient records and photographs for teaching and printing in scientific publications. All diagnostic aids, such as radiographs, are the property of the University of Kentucky.

RELEASE OF INFORMATION: Authorization is granted to the College and its staff to release pertinent information from the patient's record to any insurance company or agency which is legally responsible for all or any part of the College's service fees for treatment rendered. It is understood that release of information for any other reason than that necessary to secure payment for services rendered requires an additional authorization from the patient.

PAYMENT AUTHORIZATION: I hereby authorize payment directly to the University of Kentucky of the insurance benefits otherwise payable to me, unless special arrangements are made.

Has this child received treatment at the University of Kentucky before? _____Yes _____No

WHO SHOULD WE NOTIFY IN CASE OF AN EMERGENCY?

Name ____Phone ____________________________

____ __________________________________

Option 1 SIGNATURE of Parent or Guardian **Date**

____

PRINT Name (Circle: Father/Mother/Guardian)

OPTION 1: Informed CONSENT for Preventive Dental Care

American Dental Association Tooth Decay Risk Assessment Form PARENT/GUARDIAN, Please CIRCLE the items you can answer about your CHILD:			
	LOW RISK	**MODERATE RISK**	**HIGH RISK**
Fluoride in water/applied by dentist/toothpaste	Yes	No	
Sugary foods or drinks (juice, pop, Gatorade, medicinal syrups)	Primarily at meals		Between meals
Mother/caregiver/siblings have had tooth decay	No new cavities in last 2 years	New cavities in last 7-23 months	New cavities in last 6 months
Established patient at a dental home (has 2 cleanings per year and gets x-rays and fillings there, etc.)	Yes	No	
Name of your dentist/dental office:			
Special health care needs (developmental, physical, mental disabilities, can't brush or floss regularly)	No	Yes (>age 14)	Yes (age 6-14)
Chemo/radiation	No		Yes
Eating disorders	No	Yes	
Takes medication that reduces saliva flow	No	Yes	
Drug/alcohol abuse	No	Yes	
Has cavities Has white spots on teeth Has ever had a filling done	No new cavities or fillings in last 3 years	1 or 2 new cavities or fillings in last 3 years	3 or more new cavities or fillings in last 3 years
Teeth pulled/extracted due to cavities in last 3 years	No		Yes
Visible plaque on teeth	No	Yes	
Unusual shape to teeth that affects ability to brush	No	Yes	
Fillings that cover more than one surface of the tooth	No	Yes	
Exposed root surfaces	No	Yes	
Fillings with rough edges where food catches	No	Yes	
Orthodontics (braces or retainers)	No	Yes	
Severe dry mouth	No		Yes
YOUR OVERALL FEELING ABOUT YOUR CHILD'S TEETH RISK FOR TOOTH DECAY?	**LOW RISK**	**MODERATE RISK**	**HIGH RISK**
DENTIST'S ASSESSMENT (parent leave blank)	*LOW RISK*	*MODERATE RISK*	*HIGH RISK*

HEALTH HISTORY: (Please circle your answers.)

Circle if your child NOW has or has EVER had any of the following health problems:		
Yes	**No**	Prosthetic heart valve or repair/ history of endocarditis/ congenital heart defects/ joint replacements If so, is child supposed to take antibiotics before dental care? **Yes - No - Don't Know**
YES	**NO**	**My child is ALLERGIC to medicines (like antibiotics):** **Please LIST the medicines your child is allergic to here:** ____________________________
YES	**NO**	**My child takes MEDICINE every day for a health condition.** **Please LIST the medicines your child takes each day here:** ____________________________
Please circle any other health problems your child has: DIABETES - EPILEPSY/SEIZURES - ASTHMA - TUBERCULOSIS(TB) -		
Please list any other health issues here:		

OPTION 1: Informed CONSENT for Preventive Dental Care

Receipt of Notice of Privacy Practices (HIPAA Form)

I understand that as part of my health care, University of Kentucky and its affiliates originate and maintain health records. These health records describe my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnoses and medical treatment information to my bill
- a means by which a third-party payer (i.e. insurance company) can verify that services billed were actually provided
- and a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

The University of Kentucky and its affiliates' ***Notice of Privacy Practices*** gives a more complete description of how my health information may be used or disclosed. The Notice also explains my rights regarding my personal health information, including the right to access my own records and the right to request restrictions as to how my health information is used or disclosed.

I understand it is my responsibility to notify University of Kentucky and its affiliates regarding any restrictions to disclosure of my health information regarding this or any subsequent visit.

I have been provided with a *Notice of Privacy Practices* and have been given the opportunity to review this information. (Copies of the *Notice of Privacy Practices* are available at the school or you can call our office for a copy, (606) 439-1559 or (606) 785-3175.)

____ ____________________________

Option 1 SIGNATURE of Parent or Guardian **Date**

Consent to Receive Health Information through Email and/or Text

VERY IMPORTANT! PLEASE READ!

- Most popular email and texting services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted messages. When we send you an email or text, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet unencrypted.
- The HIPAA guidelines state that if a patient has been made aware of the risks of unencrypted email and texts, and that same patient provides consent to receive health information via email or texts, then a health entity may send that patient personal medical information via unencrypted email or texts.

ALLOW UNENCRYPTED EMAIL AND TEXTING

I understand the risks of unencrypted email and texting and do hereby give permission to the University of Kentucky HealthCare to send me personal health information via unencrypted email and via unencrypted texts.

____ ____________________________

Option 1 SIGNATURE of Parent or Guardian **Date**

Which way to do you want us to contact you about your child (circle ONE):

PHONE CALL - TEXT - EMAIL - POSTAL MAIL

OPTION 2: Informed CONSENT for Silver Diamine Fluoride

Facts

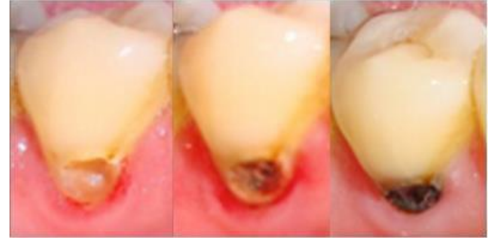
Silver Diamine Fluoride (SDF) is a liquid antibiotic. We use it on cavities to help STOP TOOTH DECAY and to treat tooth sensitivity. An application of SDF is needed every 6 to 12 months.

Treatment with SDF does not replace the need for dental fillings or crowns to repair tooth function or appearance. It is used only when a child is unable to tolerate or access dental care.

You should not be treated with SDF if you are allergic to silver or there are painful sores or raw areas in anywhere in your mouth.

Directions for use

1. Dry the affected area.
2. Place a small amount of SDF on the affected area.
3. Allow to dry for one minute.
4. Rinse.



Benefits

SDF can help **STOP TOOTH DECAY.** SDF can help relieve sensitivity.

Risks

Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that this procedure will not stop the decay, and there is no guarantee that treatment will be successful.

The affected area will stain black permanently (see photo above), but the decay will STOP.

A healthy tooth structure will not stain. A stained tooth structure can be replaced with a filling or a crown.

Tooth-colored fillings and crowns may also change color if SDF is applied to them. This is normally temporary and can be polished off.

If accidentally applied to the skin or gums, a harmless brown or white stain may appear. It does not wash off but will disappear in one to three weeks.

You may notice a metal taste; this will go away quickly.

If tooth decay is not stopped, it will continue, and the tooth will require further treatment such as another SDF, a filling or crown, a root canal, or removal of the tooth.

These side effects may not include everything reported by the manufacturer. If you notice something else, please contact your dentist.

Alternatives

No treatment: May lead to continued deterioration of tooth structures and appearance; symptoms may increase in severity

Other options: (depending on location and extent of decay) fluoride varnish, a filling or crown, extraction, or referral for advanced treatment methods

I certify that I have read and fully understand this document and that if I had any questions, I called the UK Dental Outreach Team at (606) 785-3175 and all of my questions were answered:

____ __________________________

Option 2 SIGNATURE of Parent or Guardian **Date**

OPTION 3: Informed CONSENT for Bus Trip Dental Care

PERMISSION TO TRANSPORT

Perry County Public Schools along with the UK Dental Outreach Team have agreed to work together for the benefit of the children in our community. Perry County Public Schools are providing supervised transportation from your child's school to the UK dental office in Hazard. The children will ride aboard a supervised county school bus. If your child is participating in the program, you will be contacted before the child's scheduled dental visit to obtain any necessary information that may be required and answer any questions you may have.

I give permission for my child, ___________________________________, to be transported by a bus provided by the Perry County Public School System. I understand my child will be taken from the school to the dental office and brought back after his/her dental treatment.

PERMISSION FOR DENTAL TREATMENT

Perry County Public Schools and the UK North Fork Valley Community Health Center's Dental Outreach Team would like to render dental services to your child. Our goal is to help your child achieve good oral health and empower them with the knowledge to maintain and sustain it. Your child will be treated only if your child is in need of some basic dental care, which may include the following procedures:

Dental x-rays
Treatment of decayed or broken teeth with fillings or crowns
Treatment of infected teeth or gums
Simple extractions of baby teeth if needed
Use of Nitrous Oxide (laughing gas) if needed

Because your child is a minor it is necessary to have your signed permission. Your signature affixed below authorizes examination and treatment as necessary and the use of procedures the dentist may deem necessary during the performance of his services.

I give permission for my child, _____________________________________, to be transported by bus and to receive dental treatment. I do hereby request and authorize the dentist and dental staff to perform necessary dental services for my child, and any services deemed advisable by the dentist, even if I am not present during dental treatment. Please call the school if you would like to be present for your child's dental treatment appointment. The dental clinic will attempt to call the numbers you provide below on the day of treatment to discuss the plan with you. **If you have any questions, please call the UK Dental Team at the UK North Fork Valley Community Health Center** (606) 785-3175.

By signing below, I give permission for BOTH transportation and treatment as listed above.

____ _____________________________

Option 3 SIGNATURE of Parent or Guardian **Date**