(For office use only)

Date _____ Approved by: _____

Comments _____

_____

_____

I have given this patient a medical examination and he/she

☐ (Is) ☐ (Is not) approved for dental treatment.

Pre-medication with _____ is necessary.

Comments _____

_____

Date: _____ Physician: _____

Kanawha County Dental Health Council, Inc.
100 Florida Street
Charleston, West Virginia 25302
304-348-6613

KANAWHA COUNTY DENTAL HEALTH COUNCIL, INC.

School year 2013-2014

Student _____
First Middle Last

School student is attending _____

Previous school attended _____

Current grade _____ Teacher _____

Dentist _____ Last dental visit: _____

Will your child continue to see this dentist? **YES** ☐ **NO** ☐

CONTINUE ONLY if you want to see if your child qualifies for dental treatment for 2013-2014 school year.

APPLICATION FOR SCHOOL-BASED DENTAL TREATMENT

Please complete, sign and return this application to your child's school.

↓ ↓ ↓ ↓ ↓

Student date of birth _____ ☐ Male ☐ Female

Street address_____

City_____ Zip_____

Parent/Guardian _____

Phone (H) _____ (C) _____ (W) _____

Place of employment _____

For information about making appointments in your area, call
West Side School Dental Clinic (304) 348-6613
www.kanawhadental4kids.org

Application continued inside →

Give exact information for **all** children at home:

Name	Date of Birth	School & Grade
1.		
2.		
3.		
4.		
5.		

Total number in family_____

Family household income before taxes (including income from Social Security, Unemployment, or any other income source).

Father per month $_____
Mother per month $ _____
Total $_____

☐ CHIP ☐ Medical Card ☐ Dental Insurance ☐ None

Patient Social Security Number _____

CHIP or Medical Card ID number _____

PATIENT MEDICAL HISTORY (answer each/circle any that apply)

Yes No Allergy to latex or latex products
Yes No Allergy to antibiotics (penicillin, or _____)
Yes No Allergy to dental anesthetics (Novocain, etc.)
Yes No Allergy to (food, drugs, etc) _____
Yes No Heart disease, heart murmur, pacemaker, heart defects
Yes No Arthritis, sore joints, artificial joints
Yes No Antibiotic premedication for dental treatment
Yes No Rheumatic fever, scarlet fever
Yes No High blood pressure, frequent headaches
Yes No Fainting spells
Yes No Seizures, epilepsy
Yes No Handicap or disability _____
Yes No AIDS or positive HIV test
Yes No Hepatitis, liver disease

→ → → → →

Yes No Diabetes, kidney disease, hypoglycemia
Yes No Blood disorder, anemia, leukemia, hemophilia, sickle cell
Yes No Taking birth control pills
Yes No Possibility of pregnancy
Yes No Unusual reaction to dental treatment
Yes No Excessive bleeding following injuries or dental treatment
Yes No Mental illness, anxiety, ADD/ADHD
Yes No Respiratory disease (TB, asthma, emphysema)
Yes No Currently being treated by a physician for _____

_____

Yes No Medications _____

_____

Yes No Need inhaler or medications during dental treatment

Comments_____

_____

Family Physician_____

YOUR SIGNATURE BELOW GIVES YOUR PERMISSION FOR ANY NECESSARY DENTAL TREATMENT TO BE DONE. YOU MUST BE THE PATIENT'S PARENT OR **LEGAL** GUARDIAN TO GIVE CONSENT.

Signature _____Date_____
Please circle one: Parent Legal Guardian Patient

Please print your name_____

IF YOU CANNOT TAKE YOUR CHILD TO THE DENTAL CLINIC, PLEASE SIGN BELOW. Your signature below gives permission for your child to be transported to and from the dental clinic by school bus, or excused from class to attend the clinic if it is located in their school.

Signature _____Date_____

The Kanawha County Dental Health Council is HIPAA compliant. A Notice of Privacy Practice is available upon request by calling 304-348-6613.

Signature _____ Date _____