



Jackson County Schools
Wellness Center
562 Charleston Drive
Ripley, WV 25271

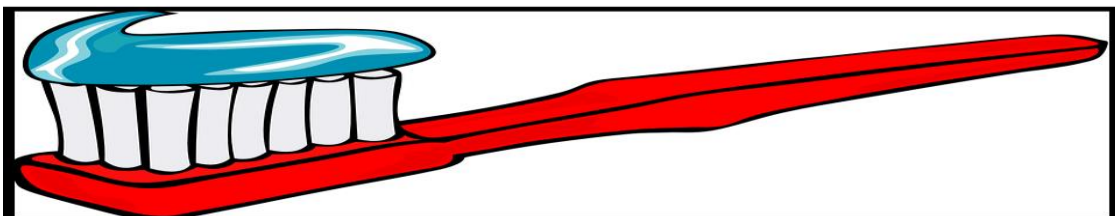
Dear Parents/Guardians,

My name is Merinda Birkett. I am the dental hygienist for the Jackson County Schools Wellness Center. I travel to all twelve schools in Jackson County to provide preventive dental services. I am currently working in conjunction with all Jackson County school nurses to provide preventive dental services to any child who does not have a regular dentist. These services include cleanings, assessments, digital x-rays, fluoride treatments, and sealants. If your child is enrolled in Medicaid, CHIP, or any other dental insurance plan, the exam will be paid for by them. If your child does not have active dental insurance, you will be charged a minimal fee of \$20 for each visit. Students are seen every six months.

Children with healthy teeth live longer, have more productive lives and higher self-esteem. The oral health of your child is important to ensure their school success, health and happiness. In accordance with WV Board of Education Policy 2423, Health Promotion and Disease Prevention, first-time entrants in pre-K or K and students entering grade 2 or grade 7 should have on file, prior to or within 45 days of enrollment, a record of an oral health examination. The dental examination should provide proof that the student completed a dental examination within the last 12 months. According to the American Dental Association, prevention and early detection can help avoid pain, trouble eating, difficulty speaking and school absences. Dental pain causes children nationwide to miss more than 51 million school hours each year. Having your child's teeth routinely checked by a dental professional can help prevent dental pain from occurring. If your child does not have a regular dentist I encourage you to enroll your child in the Portable Dental Unit for preventive services. If your child has restorative needs, you will receive referral information for a local dentist. If you would like to enroll your child in the Portable Dental Unit, please complete the entire Enrollment Form provided to you with this letter. Once completed, please return this form to your child's school nurse. Thank you!

Sincerely,

Merinda Birkett, RDH





Portable Dental Unit Enrollment Form

The portable dental unit will be at your child's school at least twice during the school year. The first visit will be during September and again in the spring. In order to schedule appointments in a timely manner, please return form to the school as soon as possible. **Please note, if your child has an appointment and the forms are not signed and returned, the appointment will be cancelled. If your child is going to another dentist and does not need these services, please notify the Wellness Center that your child does not need these services.**

Services will be billed to your insurance. If you do not have coverage, or your insurance doesn't pay, a flat fee of \$20.00 is charged for your child to be seen by the dentist. To qualify for this reduced rate, you must complete the income section of the enrollment and consent form.

If your child already has a dentist, then they do not qualify for this program. Your insurance will not cover the fees of your regular dentist and this program.

Name of Child _____ Date of Birth _____

Name of Current Dentist: _____

If your child does not have a regular dentist and you would like your child to participate in the portable dental program, Please complete enrollment and consent form for Wellness Center Services sent home with your child and the following information.

Does your child have Dental Insurance? No Yes Name of Company _____

Address: _____ Phone: _____

Effective Date: _____ Policy Number: _____ Group Number: _____

Subscribers name: _____ Birth date: _____ SS# _____

Subscribers Address: _____

Employer: _____

Medicaid: Yes or No Copy of card required. Carelink Unisys Unicare Health Plan WV Family Health

Family Case Number: _____ Child's Number: _____

Primary Care Provider listed on the Card: _____

May we leave a message on your phone with the date and time of your child's appointment if you are not available to take the phone call with the appointment information? Yes No

I, the parent or guardian of _____, give consent for him/her to participate in the portable dental service and confirm by my signature this does child does not already have a dentist.

Signature

Date

HEALTH HISTORY FORM

NAME: _____

BIRTHDATE: _____

FAMILY DOCTOR: _____

PHONE: _____

DENTIST: _____

PHONE: _____

MEDICATIONS TAKEN DAILY OR AS NEEDED BASIS

Medication _____ Dose(mg) _____ Directions: _____

Medication _____ Dose(mg) _____ Directions: _____

Medication _____ Dose(mg) _____ Directions: _____

Medication _____ Dose(mg) _____ Directions: _____

ALLERGIES

Medication(s): _____

Food: _____ Other: _____

Does the child have an order for and carry any of the follow: Check all that apply:

_____ Epi Pen _____ Insulin _____ Glucagon

MEDICAL HISTORY

List Chronic or Intermittent Disease or Health Problem (example, Diabetes, Asthma, High Blood Pressure, Sinus Infections)

SURGERY

List the type and date of the operation. (example, tonsils – Sept 2005)

SERIOUS INJURY OR ACCIDENTS

List type of accident and resulting injury and the date. (example, Football accident, broken right lower leg, Oct. 2008)

SOCIAL HISTORY

Tobacco Use: YES: Number of packs per day ____ NO

Alcohol Use: YES: Number of drinks per day ____ NO

Caffeine Use: YES NO

If you answered, Yes to caffeine use: check all sources that apply.

Sweet Soda Pop - Number per day ____ Diet Soda Pop - Number per day ____ Tea Number - per day ____

Coffee - Number per day ____ Chocolate - Number per day ____

Street Drug Use: YES Name(s) of Drug(s) _____ NO

FAMILY MEDICAL HISTORY: List disease by the appropriate family member.

Mother: _____

Father: _____

Sister: _____

Mom's Mother _____

Mom's Father _____

Dad's Mother _____

Dad's Father _____

The information I have given is correct to the best of my knowledge. I understand that my medical information will remain confidential and it is my responsibility to inform the Wellness Center staff of any changes in medical care and status.

Parent/Guardian Signature

Date