Children's Dental Clinic School Nurse Check-Off List

WellPartners provides free dental care to qualifying children attending Richland and Lexington County Public Schools.

TO QUALIFY:

Children automatically qualify if they have free or reduced lunch.
Children must not be eligible for Medicaid.
Children must not have dental insurance.

NEW ELIGIBLE CHILDREN:

Nurses must first verify eligibility. Do not give forms to children to take home to their parents until you know they are eligible.

PARENTS:

Complete and sign their child's portion of the Certification/Referral Form and their child's Health History (front and back).

NURSES:

Please sign and date child's Certification/Referral Form and include your contact phone number. Schedule the first appointment after all information is completed by parent. Please inform parents that all children are seen in the order in which they were signed in. Inform parents that they are asked to remain in the waiting area while their child is having dental treatment.

RECERTIFING ELIGIBLE CHILDREN:

Each child must be re-qualify for eligibility every two years. The WellPartners staff will notify parents to contact school nurse and the school nurse will go through the original process of eligibility.

Tooth decay affects children in the United States more than any other chronic infectious disease. Untreated tooth decay causes pain and infections that may lead to problems; such as eating, speaking, playing and learning.

The good news is that tooth decay and other oral diseases that can affect children are preventable. The combination of dental sealants and fluoride has the potential to nearly eliminate tooth decay in school-age children.

Centers for Disease Control and Prevention (CDC), 2012

Your children may qualify for FREE dental services through WellPartners. Contact your child's school nurse for further information.

Information for Mothers:

Poor oral health of the mother, including dental decay and periodontal disease before and during pregnancy, has been linked to poor birth and pregnancy outcomes such as preterm birth and low birth-weight. In addition, ensuring good oral health for women during the perinatal period plays a vital role in promoting the oral health of her children after birth.

Increasing evidence suggests that maternal gingivitis and periodontitis may be a risk factor for preterm birth and other adverse pregnancy outcomes.

National Maternal and Child Oral Health Resource Center (NMCOHRC), 2008
Journal of American Dental Association (JADA), 2012

Contact the Palmetto Health-Healthy Start Program for further information. 803-296-3780 or 800-249-4340

Children's Dental Clinic

WellPartners Adult & Children's Dental Clinics **Lexington County Health Department** **Red Bank Crossing** **1070 South Lake Dr., Suite B** **Lexington, SC 29073** **Phone: 803-888-3271**	**WellPartners Children's Dental Clinic** **Richland County Health Department** **2000 Hampton Street, Suite 4090** **Columbia, SC 29204** **Phone: 803-888-1590**

CERTIFICATION / REFERRAL FORM

Check one: □ **New** □ **Recertification**

Child's Name: _____
Last **First** **Middle**

Birth date: _____ **Social Security #:** _____

County: _____ **Name of School:** _____

Name of Parent/Guardian: _____ **Phone #:** _____

Address: _____
Street

_____
City/State/Zip

□ **Check here to certify that the above-named child is eligible and has been properly certified to receive services at the Children's Dental Clinic.**

Nurse/Staff Member: _____ **Phone#:** _____
School/Agency: _____ **Date:** _____

Parental Permission: I give my permission for the above-named child to receive full dental treatment from the Children's Dental Clinic, which includes all standard dental procedures and may involve the administering of anesthesia. I understand that a prescription for medication may be prescribed by the dentist, if needed. I further release from liability the staff and volunteers of the Children's Dental Clinic. This program is funded by the United Way of the Midlands.

*****Signature of Parent/Guardian:** _____

Appointment made for: _____, **on** _____
Time **Date**

Children's Dental Clinic	
WellPartners Adult & Children's Dental Clinics **Lexington County Health Department** **Red Bank Crossing** **1070 South Lake Dr., Suite B** **Lexington, SC 29073** **Phone: 803-888-3271**	**WellPartners Children's Dental Clinic** **Richland County Health Department** **2000 Hampton Street, Suite 4090** **Columbia, SC 29204** **Phone: 803-888-1590**

CHILD'S HEALTH HISTORY

The following questions and answers are for our records only and will be considered confidential.

Last medical exam: _____ Physician: _____ Phone#: _____

Physician's Address: _____

Is your child now under a physician's care? □ Yes □ No
If yes, why? _____
Is your child currently taking medications? □ Yes □ No
If yes, what medications? _____
Is your child a hemophiliac (bleeder)? □ Yes □ No
Has your child been hospitalized? □ Yes □ No
If yes, reason for hospitalization: _____

Indicate if your child has, or had, any of the following

CONDITIONS—DISEASES—TREATMENTS

Anemia	**□ yes**	**□ no**	**Sinus Problems**	**□ yes**	**□ no**
Asthma	**□ yes**	**□ no**	**Thyroid Condition**	**□ yes**	**□ no**
Seasonal Allergies/Hay Fever	**□ yes**	**□ no**	**Kidney or Liver Disease**	**□ yes**	**□ no**
Diabetes	**□ yes**	**□ no**	**Fainting or Dizzy Spells**	**□ yes**	**□ no**
Hepatitis or Jaundice	**□ yes**	**□ no**	**Nervous Habits/Problems**	**□ yes**	**□ no**
Epilepsy or Seizures	**□ yes**	**□ no**	**Eating Disorders**	**□ yes**	**□ no**
Stomach or Intestinal Bleeding	**□ yes**	**□ no**	**High or Low Blood Pressure**	**□ yes**	**□ no**
Prolonged bleeding from cut/surgery	**□ yes**	**□ no**	**Stroke**	**□ yes**	**□ no**
Abnormal Heart Disease/Defect	**□ yes**	**□ no**	**Venereal Disease**	**□ yes**	**□ no**
Rheumatic Fever or Heart Disease	**□ yes**	**□ no**	**Radiation Treatment**	**□ yes**	**□ no**
Heart Murmur	**□ yes**	**□ no**	**Blood Transfusion**	**□ yes**	**□ no**
Tuberculosis (TB)	**□ yes**	**□ no**	**AIDS/HIV Positive**	**□ yes**	**□ no**
Arthritis	**□ yes**	**□ no**	**Malignancies**	**□ yes**	**□ no**

Indicate if your child has, or had, any of the following

ALLERGIES - REACTION

Local Anesthetic (Novocaine)	**□ yes**	**□ no**	**Aspirin**	**□ yes**	**□ no**
Penicillin or other Antibiotics	**□ yes**	**□ no**	**Ibuprofen**	**□ yes**	**□ no**
Sulfa Drugs	**□ yes**	**□ no**	**Codeine**	**□ yes**	**□ no**

Is your child pregnant? **□ yes** **□ no**

Is your child considered to be handicapped? **□ yes** **□ no**

If yes: **□ Physical** **□ Mental** **□ Emotional**

Does your child have any other condition not listed above? **□ yes** **□ no**

If yes, please describe condition and any treatment: _____

_____

_____

Date of last dental care: _____ Where? _____

Child's Name: _____

Last First Middle

□ Check Box – The above information, to the best of my knowledge, is correct.

***Signature of Parent/Guardian: _____

Does the above listed patient or patient's family have any special needs that must be met in order to schedule treatment? Such as:

Scheduling Difficulties:	**□ yes**	**□ no**	**_____**
Transportation:	**□ yes**	**□ no**	**_____**
Other:	**□ yes**	**□ no**	**_____**