Tri-City CUSD #1

324 West Charles Street
Buffalo, Illinois 62515

Christy Kindel
JH/HS Principal
Phone: (217) 364-4530
Fax: (217) 364-4812
kindel@tricityschools.org

Jill Larson
Superintendent
Phone: (217) 364-4811
Fax: (217) 364-4896
jlarson@tricityschools.org

Kara Cummins
Elementary Principal
Phone: (217) 364-4035
Fax: (217) 364-9418
kcummins@tricityschools.org

January 11th, 2018

Dear Parents/Guardians,

The school district is excited to offer the mobile dentistry program "Miles of Smiles" to our student population again this spring. We hope this program will help alleviate some of the financial demand placed on families as they meet requirements for school.

All children, preschool through 12th grade, are eligible for an exam. The services are provided at "no cost" to our district families.

As an additional benefit to our district families, the team fills out dental forms which meets the requirements for students in kindergarten, 2nd and 6th grades who are required by law to show proof of a dental examination for school.

Here is how the program works:

Parents fill out the attached permission slip and return it to the Nurse's Office by Monday, February 26th, 2018.

A team including a dentist, hygienist and dental assistants will come to the school during the school day to give examinations in the Nurse's Office.

The team will be at Tri-City on Tuesday, March 6th, 2018, at 9:00 a.m.

Examinations will not be given unless a permission form is completely filled out and returned to the nurse's office.

I encourage families to take advantage of this opportunity. Please contact me with any questions or concerns.

Thank You,

Kathy Getz, RN

Kathy Getz, RN
Tri-City School Nurse
(217)364-4035 x117
kgetz@tricityschools.org

ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

Rev.05/15

PLEASE PRINT IN INK

DENTAL EXAM

Services Rendered By:
Miles of Smiles, Ltd.
137-C Radio City Dr.
North Pekin, IL 61554
309-382-6404

MUST BE RETURNED TOMORROW **(ONLY IF YOU *WANT* THESE SERVICES)**

NAME OF SCHOOL:_____

TEACHER:_____ GRADE: _____

COUNTY:_____

DO YOU HAVE A DENTIST? YES / NO **DENTIST'S NAME:** **EXAM DATE:**

PROVIDE THE FOLLOWING INFORMATION ONLY IF YOU WANT THESE DENTAL SERVICES
to be rendered by Miles of Smiles, Ltd at school.

Dear Parent or Guardian,

Miles of Smiles, Ltd. and The Illinois Department of Healthcare and Family Services have arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, hygienists, and assistants will come to your child's school with portable equipment. In order for your child ***to receive these services***, you must **PROVIDE ALL THE INFORMATION** REQUESTED BELOW **AND SIGN** IN THE AREA INDICATED.

YOUR CHILD'S LEGAL NAME:_____ BIRTH DATE: ____/____/____

ADDRESS:_____ GENDER: M / F

CITY/ZIP:_____ HOME PHONE: _____-_____-_____

DOES YOUR CHILD QUALIFY FOR FREE OR REDUCED MEALS: YES / NO

IS YOUR CHILD ENROLLED IN THE 'Medicaid/All Kids' PROGRAM: YES / NO

MCO COMPANY NAME (if not listed): _____

MCO COMPANY NAME (circle one): Aetna, BCBS, Cigna, Health Alliance Connect, Humana, Illini Care, Harmony, Meridian, Family Health Network, Molina

IF YES, INCLUDE YOUR **CHILD'S RECIPIENT ID NUMBER:** → _____

Medicaid/All Kids will be billed

(9 DIGIT ID NUMBER ON BACK OF MEDI-PLAN CARD)

IS YOUR CHILD COVERED BY PRIVATE DENTAL INSURANCE: YES / NO (if incomplete, only grades K, 2nd, & 6th may be eligible for an exam)

If YES, please fill out **ALL** the insurance information below: ***(DENTAL INSURANCE COMPANY WILL BE BILLED)***

Name of Dental Insurance Company:_____

Dental Insurance Company Address:_____

Member's (employee) ID *or* SS #:_____ Dental Insurance plan or **group number:**_____

Member's Name:_____ **Member's** Birth Date:_____

Member's Address *(if different than child's)*:_____

Member's Phone Number *(if different than child's)*:_____ Employer:_____

Has your child had any history of, or conditions related to, any of the following: (Please circle)							
Anemia:	YES / NO	Chronic Sinusitis:	YES / NO	Growth problems:	YES / NO	Seizures:	YES / NO
Asthma:	YES / NO	Diabetes:	YES / NO	Hearing:	YES / NO	Thyroid:	YES / NO
Bleeding disorders:	YES / NO	Ear aches:	YES / NO	Heart Disease:	YES / NO	Tobacco / drug use:	YES / NO
Cancer:	YES / NO	Epilepsy:	YES / NO	Latex allergy**:	YES / NO	Allergies:	
Cerebral Palsy:	YES / NO	Fainting:	YES / NO	Pregnancy (teens):	YES / NO	Other:	
Is your child taking any prescription and/or over the counter medications at this time? YES / NO							
If yes, please list:							
Does you child have any known heart condition? YES / NO DESCRIBE:							
Does your child have any artificial joints: YES / NO IF YES, WHEN & WHAT JOINT:							
Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatment? YES / NO							
IF YES, WHAT:							

IMPORTANT: PARENT/GUARDIAN SIGNATURE REQUIRED ***(ONLY IF YOU WANT THESE SERVICES)***

I am a custodial parent or legal guardian of the minor child named above. **I authorize and consent to** this child receiving the dental **treatment** described, and allow the school nurse/ school representative and dental provider access to child's dental record.

This will also give permission for the Illinois Department of Public Health to provide Quality Assurance Audits by evaluation of your child's sealants that were placed at the school. Upon determination, this permission will also allow for the sealants to be replaced by the provider if indicated.

I also consent to be contacted by the **Central Counties Health Centers, Inc.** to schedule a follow up appointment if needed.

To the extent permitted by law, I consent to the use and disclosure of the minor child's protected health information to carry out payment activities in connection with this claim. I hereby **authorize and direct payment** of the dental benefits directly to Miles of Smiles, Ltd.

SIGNATURE: **PRINT NAME:** **DATE:**

IF YOU HAVE A DENTIST, SEEK DENTAL CARE THERE! DDS INITIALS_____ RDH INITIALS_____