HEALTH *FIRST*™
BLUEGRASS

Place Label
Here

For Pediatric Patients Only:

Outreach Dental Clinic Consent

The Health*First* Bluegrass dental team visit several Fayette County Public Schools to provide both preventative and restorative dental care. If your child's school has a HealthFirst Bluegrass School Based Clinic on-site, the dentist will be in the clinic once a week to complete dental exams and screenings. The mobile clinic typically visits schools once per semester for a few days at a time. They offer all facets of dentistry, including cleanings, sealants, fluoride treatments, restorations (fillings), and extractions. Our goal is to bring the dentist to you, limiting the need for missing work or your child to miss school for a dental appointment. If your child attends a school where we provide dental care, and they are scheduled to be seen by the dental team, you will be contacted verbally prior to the appointment.

I give my consent for _____ _____ _____

PATIENT'S FULL NAME **DATE OF BIRTH** **SOCIAL SECURITY #**

To receive any of the following services at Health*First* Bluegrass, Inc. Dental Clinics, including the Mobile Clinic:

1. Diagnostic and treatment procedures including clinical exams, fluoride treatment, cleanings, x-rays, silver and/or white fillings, stainless steel crowns, nerve treatment, soft tissue removal, and all local anesthesia by authorized agents and employees of Health*First* Bluegrass and the dental staff, or their designees, as may in their professional judgment be deemed necessary or beneficial. I understand that certain risks and complications may happen if my child has these procedures. These possible problems include: The possibility of discomfort during and following treatment, aspiration or swallowing a dental instrument or dental material, allergic reactions to dental materials, and other possible problems that the dentist cannot predict.

I understand that:

1. My child may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
2. When baby teeth are removed, it can cause problems for the erupting teeth and my child may need a space maintainer to keep the space open for the permanent tooth to come in. I also understand that space maintainers are not placed as a part of this program and that a referral letter will be sent home if necessary.
3. There also may be instances when treatment on a tooth cannot be immediately performed, but in order to prevent an abscess or further infection, the staff may place a topical fluoride to stop the active decay process. While there are no health risks involved, black or dark staining of the decayed surface will occur.

I authorize Health*First* Bluegrass dental personnel to apply this material at their discretion. Please initial Yes____ No____

4. These services will be provided by the dental faculty, students, hygienists and/or staff of Health*First* Bluegrass.
5. The preventive treatment (cleaning, fluoride and sealants) may be provided by a registered dental hygienist without the presence of the dentist, as outlined in general supervision legislation.
6. 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.
7. There may be instances where the DMD is unable to save a tooth when trying to restore it. In these instances, the only alternative is to extract (pull) the tooth. There are risks involved with having teeth removed. While infrequent, these risks may include: pain, excessive bleeding, infection, swelling, bruising, jaw stiffness, damage to adjacent or underlying teeth, breaking of a root tip, etc.
8. While all the individual records are held by Health*First* Bluegrass, Inc. as confidential, I understand that a list of children who need follow-up dental treatment is routinely provided to the school's Family Resource Center, so that they may assist with getting follow up care, when needed.

I authorize HealthFirst Bluegrass staff to share my child's name with the Family Resource Center at their school.

Please initial Yes____ No____

_____ _____ _____

Date **Signature of Patient, Parent, Legal Agent/Guardian** **Relationship to Patient**