Chicago Public Schools

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

School Based Oral Health Program
Dental Consent, Release of Liability and Authorization Form

Student Name: _____ Student's Date of Birth_____ ☐ Male ☐ Female

School Name: _____ Student ID# _____Grade: _____Room# _____

Parent/GuardianName:_____HomeAddress: _____

Phone Number:_____ Zip Code: _____ Medicaid/ALL KIDS - 9 Digit Recipient #_____

As the parent/guardian of the above named student, I understand that through the City of Chicago Department of Public Health and the Chicago Public School's **SCHOOL-BASED ORAL HEALTH PROGRAM** (the "**PROGRAM**"), licensed dentists will be coming to my child's/ward's school in the near future to provide a **DENTAL EXAM/SCREENING, DENTAL CLEANING, FLUORIDE TREATMENT** and apply **Dental SEALANTS (AS NEEDED)** at **NO COST** to students or their families in the school. Dental sealants, in addition to regular brushing and flossing, protect your child's/ward's teeth from **DECAY**. Dental Sealants are thin, plastic coatings put on the tops of the back-teeth to SEAL OUT food and germs. Sealants are applied on teeth that appear not decayed, and they don't hurt. **PROGRAM SERVICES DO NOT INCLUDE DRILLING OR SHOTS.**

I understand that in consideration for my child's/ward's participation in the **PROGRAM**, and as evidenced by my signature below, I hereby release and hold harmless the **CITY OF CHICAGO**, its departments, including the Department of Public Health, and its employees, officers, volunteers, agents and representatives, and **THE BOARD OF EDUCATION OF THE CITY OF CHICAGO**, its members, trustees, agents, officers, contractors, volunteers and employees from any liability which may accrue to me or to my child/ward, for any and all losses, injuries, damages to me or my child/ward, both known and unknown, foreseen and unforeseen, arising in connection with my child's/ward's participation in the **PROGRAM** whether or not said losses, injuries, damages, or liabilities result in whole or part from the negligence of the **CITY OF CHICAGO**, its departments, including the Department of Public Health, its employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the BOARD OF EDUCATION OF THE CITY OF CHICAGO, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives.

I further understand that as evidenced by my signature below, I acknowledge that a licensed dentist providing medical or dental care, treatment, diagnosis, or advice without charge on behalf of the City of Chicago Department of Public Health is not liable for civil damages resulting from his or her acts or omissions in providing such medical or dental care, treatment, diagnosis, or advice under the Program except for willful or wanton misconduct. To authorize dental providers and the Chicago Department of Public Health to share information relating to PROGRAM dental services provided to your child/ward, please sign the Authorization Form that is on the other side of this page. This signed consent form is valid for **365** days from the date that it is signed by the child's/ward's parent or guardian.

Race: (Please circle one) White Black Asian / Pacific Islander American Indian/ Native Alaskan **Hispanic** (Please circle one) Yes No

MEDICAL INFORMATION: Has your child/ward ever had any of the following: **YES or NO** If YES: Please circle the appropriate condition below:

Asthma Diabetes Currently has Heart Murmur Rheumatic Fever or Rheumatic Heart Disease Epilepsy Blood Disorder / Disease Hepatitis

Is your child/ward taking any medication? If YES, Please list medication: _____

Does your child/ward have any Allergies? If YES, Please list Allergies: _____

Any other medical related conditions? If YES, Please list the conditions: _____

As the parent or guardian of the above - named child or ward, I consent for my child or ward to participate in the SCHOOL-BASED ORAL HEALTH PROGRAM, which includes a dental exam/screening, dental cleaning, gel or varnish fluoride treatment, the application of dental sealant(s) if appropriate, and the receiving of Quality Assurance exams. I authorize the dental provider to use my child's or ward's Medicaid, ALL KIDS number for billing purposes only. **I understand that if I fail to sign this Dental Consent Form and Release of Liability, my child or ward will not receive any services under this program.**

Please sign both sides:

Parent/Guardian _____ **Date:** _____

Chicago Public Schools

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

School - Based Oral Health Program Authorization Form – HIPAA

Student Name:_____ Student Date of Birth: _____

School Name: _____ Parent/Guardian Name: _____

By signing below, I understand that I am giving my authorization to the dental provider and the City of Chicago Department of Public Health to use and/or disclose my child's/ward's protected health information, to the following person(s) or organization(s) for the purposes of reports, documentation of oral health trends, and Medicaid and grant billing: City of Chicago, Department of Public Health, 333 S. State Street, 2nd Floor, Chicago, Il 60604; Individual School Principal; Illinois Department of Healthcare and Family Services, 201 So. Grand Avenue East, Springfield, Il, 62763; Illinois Department of Public Health - Oral Health Division, 535 W. Jefferson Street, 2nd Floor, Springfield, Il, 62761, Chicago Public Schools, Office of Student Health and Wellness, 42 West Madison, Garden Level, Chicago Illinois 60602. Federally Qualified Health Centers, Infant Welfare Society of Chicago (IWS), 3600 W Fullerton Ave, Chicago, Oak Park-River Forest Infant Welfare Clinic, 320 Lake Street, Oak Park, Il 60302 and Chicago Public School approved Dental Vans.

CDPH and dental providers may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization. This Authorization is voluntary and I may refuse to sign it. I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA) and federal privacy regulations. I may revoke this Authorization in writing by sending notice to the HIPAA Privacy Officer, City of Chicago, Department of Public Health, 333 S. State Street, 2nd Floor, Chicago, Il 60604. Revocation is not effective with respect to actions taken prior to the revocation. This authorization is valid for **365** days from the date that it is signed by the child's/ward's parent or guardian.

Please sign both sides:

Parent/Guardian _____ Date _____