KŌKUA KALIHI VALLEY
DAVID R. BREESE CENTER FOR COMMUNITY ORAL HEALTH
2229 N. SCHOOL STREET ◆ HONOLULU, HAWAI`I 96819 ◆ TEL: 808-791-9428 ◆ FAX: 808-848-0979 ◆ www.kkv.net/dental

Dear Parent/Guardian,

Kokua Kalihi Valley (KKV) is offering a preventive dental program for all the students at your child's school. Licensed dental providers will come to the school to provide oral health screening (without x-rays), dental cleaning, fluoride treatment and dental sealants (a coating to help prevent tooth decay). An oral health report card will be sent home with your child along with a toothbrush kit and oral home care instructions.

The services which your child will receive in this program are not meant to be an alternative to regular dental care. It is recommended that you seek out a dental home (family dentist) for routine dental care including any follow-up care which may be recommended.

Due to the pandemic, we are very concerned about the health and safety of our children. Our licensed dental providers will be following health and safety guidelines from the Centers for Disease Control and Prevention (CDC), American Dental Association (ADA) and Hawaii Department of Education (HIDOE).

Please complete the *front side only* of the attached form and return it to your child's teacher. A parent's or guardian's signature is required for your child to participate in our Oral Health Prevention and Outreach Program.

Thank you very much,

KKV Dental Team

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Oral Health Prevention and Outreach Program

PERSONAL INFORMATION

Name of School _____ **Teacher**_____ **Grade** _____

Child's Name _____ **Date of Birth** _____ **Gender (circle):** Male / Female
Last First MI

Parents/Guardian Name_____

Address _____ **City** _____ **Zip** _____

Are you a public housing resident? Yes ☐ No ☐ **Email Address** _____

Primary Phone_____ **Cell Phone** _____ **Work Phone** _____

Ethnicity (check all that apply)

☐ Filipino ☐ Samoan ☐ Laotian ☐ Micronesian ☐ Korean ☐ Hawaiian ☐ Caucasian ☐ Chinese ☐ Vietnamese

☐ Other _____

INSURANCE INFORMATION

Dental Insurance Company _____ **Subscriber Name** _____

Dental ID #_____ **Group #** _____ **Subscriber Date of Birth** _____

MEDICAL AND DENTAL HISTORY

Has your child received a regular medical check-up for a well-child exam within the past 12 months? □ Yes □ No

Does your child have any medical problems? □ Yes □ No **If yes, check or list them:** □ Heart Problems □ Artificial Heart Valve □ Rheumatic Fever □ Diabetes □ Asthma □ Seizure Disorder □ Other_____

Does your child take any medications? □ Yes □ No
If yes, list your child's medications:_____

Does your child have any allergies?: □ Yes □ No **If yes, list your child's allergies:**_____

Has your child received a regular dental check-up (cleaning, exam, fluoride) within the past 12 months? □ Yes □ No
If yes, where do they receive dental care? _____

CONSENT

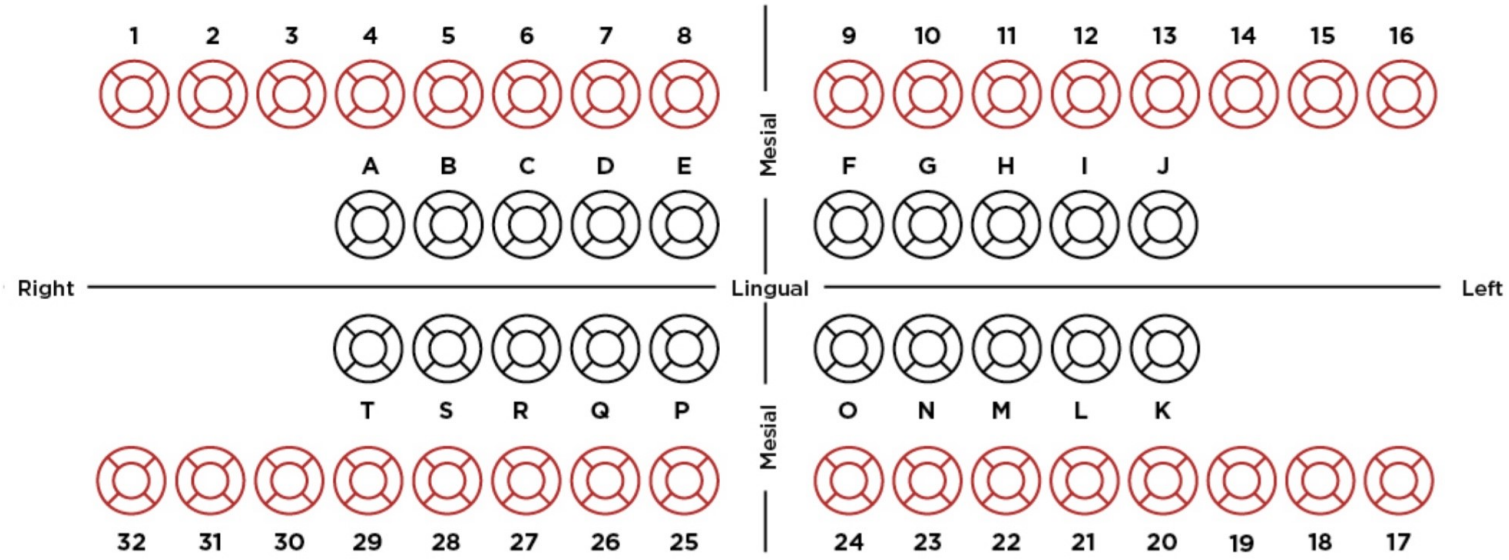
I allow my child to be treated by the Oral Health Prevention and Outreach Program. I understand that by signing this form, I consent to have my child receive an oral health assessment, dental cleaning, fluoride treatment and if recommended, dental sealants. I also give my permission for KKV to bill my insurance for any services provided to my child. KKV's Notice of Privacy Practices is available for review at any time. I understand that the information given by me and/or collected and stored in my child's health record is necessary for the KKV staff to provide services for my child's health and well-being. My child's health record shall not be disclosed to another agency or person, unless for treatment or payment purposes.

PARENT OR GUARDIAN'S SIGNATURE

_____ _____ _____ _____
Printed Name Relationship Signature Date

THIS SIDE FOR STAFF USE ONLY

Name:_____



Prophylaxis Date:_____ **Fluoride Date:**_____

Sealant Date:_____ **Sealants Completed:**_____

UDS Sealant Exclusion?: ☐ *Yes* ☐ *No*

Plaque: ☐ *Light* ☐ *Moderate* ☐ *Heavy*
Calculus: ☐ *Light* ☐ *Moderate* ☐ *Heavy*
Bleeding: ☐ *Light* ☐ *Moderate* ☐ *Heavy*

Did the child have breakfast this morning? ☐ *Yes* ☐ *No*
If yes, what did the child have for breakfast? _____

Oral Hygiene Grade: ☐ *Poor* ☐ *Fair* ☐ *Good*

Referral Level: ☐ *Immediate* ☐ *Urgent* ☐ *Early* ☐ *No obvious problems*

Assessment Provider: _____ **Assistant:**_____

Sealant Provider: _____