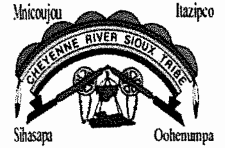


Cheyenne River Head Start Program

Application for SY 2023-2024

RETURNING STUDENT (2ND OR 3RD YEAR)

To be **COMPLETE**, the following must be submitted:

_____**Physical Examination:** This **MUST** be turned in **BEFORE** your child can begin school.

CRST Field Health:	964-0772	**Eagle Butte:**	
Cherry Creek Clinic:	538-4251	Indian Health Service:	964-7724
Red Scaffold Clinic:	538-4403	Horizon Health Center:	964-8000
Swiftbird Clinic:	733-2174	Upell Clinic	964-7700
White Horse Clinic:	733-2133		
Timber Lake		**Faith Community Clinic**	967-2644
West Dakota Health	865-3258	**Isabel Clinic**	466-2120
Community Health/WIC	865-3587		

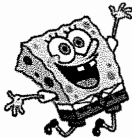
_____ **Hematocrit/Hemoglobin is Required:.**

_____ **Lead Results (ONLY if there is NO lead results on file)**

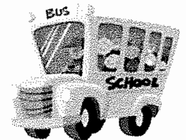
_____**Updated Immunization:**

_____**Income Documentation (If child is attending for the 3rd year, a current income MUST be submitted**

ALL documents MUST be submitted to the Family Services before the 1st day of School.



Call 964-8713 for information:
Rita Kym Louis, Family Services Manager



If you DO NOT want your child to be taken for vision or hearing screenings by Head Start, it will be the parents/guardians responsibility to submit results of these screenings within 45 days of the child's first day of school.

Cheyenne River Head Start Program
CHILD APPLICATION
P. O. Box 590, Eagle Butte, SD 57625
Phone: 605-964-8713 Fax: 605-964-8705

Office Use Only:
Date Received________________
Center: ________________

TEACHER REQUEST (EB ONLY): ____________________

What center is application for?: ______________________ **Is Child:_ New:** _____ **Returning:** _____

Please COMPLETE all areas of this application. **Chronological Age:**__________

Applicant Information: First Name: MI Last Name:	**Date of Birth:**	**Gender:** Male: ________ Female: ________

Parents/Guardians E-MAIL:
Mother: ______________________ **Father:** ______________________
Guardian:______________________

Living Address:
Street/House No.: ______________________
Town/City: ______________________

Mailing Address of Primary Adult (physical custody)
Street/P.O. Box: ______________________
Town/City: ______________________

Child lives with: (Check all that applies)

☐ Mother ☐ Father ☐ Step-Father ☐ Step-Mother ☐ Foster Parent(s) ☐ Legal Guardians
☐ Grandparent(s) ☐ Other Relative Other (specify): ______________________

Ethnicity of Child:

☐ American Indian/Alaska Native ☐ Asian ☐ African American or Black
☐ BiRacial/Multi-Racial ☐ Native Hawaiian or Pacific Islander ☐ White

Household Composition/Ethnicity: AI/AN: American Indian/Alaska Native **Asian** **AA:** African American or Black
MR/BR: Multiracial or Biracial **NH/PI**: Native Hawaiian or Pacific Islander **W**: White

First Name: Last Name:	Date of Birth	Relationship to Child:	Ethnicity:

Child and/or Family Information:

Is family on SNAP: Yes: ____ No ____ Is child on WIC: Yes: ____ No ____ Is family on SSI? Yes: ___ No: ____
Is family on TANF Yes: _____ No: _____ Formerly on TANF: Yes: ____ No: ____
Is family homeless: Yes:____ No: ____ Is child toilet trained: Yes: ____ No: ____
Does child have food and/or milk allergy: Yes: ____ No: ____ (Form signed by Dr. must be submitted)
Is child on IEP (Individual Education Plan)? Yes: ____ No: ____
Primary language of child: ______________________ 2nd Language of child: ______________________

Medical Information for Child:

Is child currently on: ☐ Medicaid Only ☐ CHIP Only ☐ Combined Medicaid/CHIP ☐ Private Insurance ☐ Military Insurance ☐ No Insurance

Medicaid/CHIP number: ____________________

Do you utilize Indian Health Service: ☐ Yes ☐ No

Medical Home (name of hospital/clinic): ____________________

Address: ____________________ Phone Number: ____________

Does child have access to regular dental care: ☐ Yes ☐ No Utilize I.H.S.____________

Dental Home (name of dentist/dental clinic): ____________________

Address: ____________________ Phone Number: ____________

Primary Adult:	**Secondary Adult:**
First Name: MI Last Name	First Name: MI Last Name:
Date of Birth: Relationship to Child:	Date of Birth: Relationship to Child:

Telephone Number Information:	**Telephone Number Information:**
Home: ____________ Work: ____________	Home: ____________ Work: ____________
Cell: ____________ Message: ____________	Cell : ____________ Message: ____________

Primary Adult Employment & Education

Employment:

☐ Full Time ☐ Part-Time ☐ Seasonal ☐ Unemployed ☐ Self-Employed

Employer name: ____________________

Are you attending school/job training? ☐ Yes ☐ No

If Yes, where: ____________________

Are you active in any branch of the United States Military?

☐ Yes ☐ No

Are you a **Veteran** of the United States Military?

☐ Yes ☐ No

Highest level of education completed:

☐ 9th or less ☐ 10th ☐ 11th ☐ 12th (didn't finish)

☐ High School graduate ☐ GED ☐ Some college

☐ Associate's Degree ☐ BS/BA ☐ MA/MS

☐ Vocational ☐ Doctorate ☐ Other: ____________

Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ African American or Black ☐ Bi-Racial/Multi-Racial ☐ Native Hawaiian or Pacific Islander ☐ White

Secondary Adult Employment & Education

Employment:

☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Unemployed ☐ Self-Employed

Employer Name: ____________________

Are you attending school/job training? ☐ Yes ☐ No

If Yes, where: ____________________

Are you active in any branch of the United States Military?

☐ Yes ☐ No

Are you a **Veteran** of the United States Military?

☐ Yes ☐ No

Highest level of education completed:

☐ 9th or less ☐ 10th ☐ 11th ☐ 12th (didn't finish)

☐ High School graduate ☐ GED ☐ Some college

☐ Associate's Degree ☐ BS/BA ☐ MA/MS

☐ Vocational ☐ Doctorate ☐ Other: ____________

Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ African American or Black ☐ Bi-Racial/Multi-Racial ☐ Native Hawaiian or Pacific Islander ☐ White

Transportation/Emergency Contact:

Pick-Up: Will bring in: ________

House Number: __________

Street/Housing Area: ____________________________

Drop-Off: Will pick up: __________

House Number: __________

Street/Housing Area: ________________________

Emergency contact: Please **DO NOT** list yourself; this person will be contacted when the parent/guardian cannot be reached:

Name of Person: ____ Relationship to Child: ________________

House Number: __________ Street/Housing Area: ____

Phone Numbers: Home: _________________ Work: ________________ Cell: _________________

Release: Please list the people who you authorize to pick up your child from the center/classroom:

____

____

Volunteer:

Mother:	Father:	Guardian	Activity:
			Read stories to children in classroom
			Help in kitchen (cooking, washing dishes, etc.)
			Assist teaching staff with prep time
			Assist with Week of the Young Child activities

_________ **NO,** I cannot volunteer at this time.

Parent Consent:

While my child is participating in the CRST Head Start Program, I agree to the following:

_____ Yes _____ No 1. I give consent for my child to be transported for an emergency or to services to and from the center for educational field trips, neighborhood walks

_____ Yes _____ No 2. I give consent that, in case of an emergency and if the parent/guardian cannot be contacted, qualified Head Start personnel may provide first aid or obtain emergency medical care, if needed.

_____ Yes _____ No 3. I give consent that, my child may receive all necessary health (vision, dental, hearing) and developmental (DIAL-4) screenings, assessments

_____ Yes _____ No 4. Mental Health professional will be making routine mental health observations at Cheyenne River Head Start centers. I hereby give my permission for the mental health professionals to review my child's records, if needed.

_____ Yes _____ No 5. I give authorization for my child's file to be transferred to the parent/school, if requested by either parent or school.

All children's records are kept in locked filing cabinets with an access form. Statistical data will be used for the annual Program Information Report (PIR).

I certify that the information provided on this application is correct and to the best of my knowledge. If any information changes during the school year, I understand that it will be my responsibility to inform the staff.

Parent/Guardian Signature: ____ Date: ____________

EMERGENCY CONTACT INFORMATION

Child's Name: ______________________________

Date of Birth: ______________________________

Physical Address: ______________________________

Mailing Address: ______________________________

Parent/Guardian (Mom) ______________ (C) ________ (H) ________ (W) ________

Parent/Guardian (Dad): ______________ (C) ________ (H) ________ (W) ________

Alternate Emergency Contact Person:

Name: ____________ Relationship: ____________ Phone #: ____________

Name: ____________ Relationship: ____________ Phone #: ____________

Name: ____________ Relationship: ____________ Phone #: ____________

Medical Information (any allergies to medications, food or other substances):

____

____

Authorized People to Pick up Student:

____

____

Child's Primary Care Provider: ______________________ Phone #: ____________

Does your child have Asthma?: Y / N Does child have a Asthma Action Plan? Y / N

Is your child on an IEP? Y / N

I agree that the teacher/teacher aide may authorize the physician of his/her choice to provide emergency medical care in the event that neither Parent/Guardian, alternate contact(s) can be located immediately.

Parent/Guardian Signature: ______________________ Date: ____________

Cheyenne River Head Start Program
One Call

Parents/Guardians:

The Cheyenne River Head Start Program has implemented the One Call System. By implementing this system, the program will be able to send out notifications to the parents in a timely manner.

The notifications could exist of

- No school
- Early school dismissal
- Parent/Teacher Conferences
- Parent Activity Nights
- Weather related school cancellations
- Cancellation of Bus services due to road conditions
- Other mass notifications that will be sent to the concerned parties

Please Fill Out This Form

Name of Parent/Guardian:______________________________

Name of Child:______________________________

Center:

Cherry Creek	**Dupree**	**Eagle Butte**	**Swift Bird**
Red Scaffold	**Timber Lake**	**White Horse**	

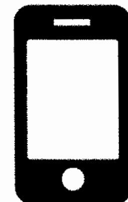
Classroom:_________________________

Contact Information:

Home Phone:______________________

Cell Phone:______________________

Email:__________________________



Indian Health Service

OPTOMETRY CLINIC

Eagle Butte, South Dakota 57625

Child Vision History

(Please complete this form for your child; this is taken to the Optometry Office when child is screened)

Child's Name: ______________________________ DOB: __________
Address: ______________________ Home Phone: __________
______________________ Cell #: __________

Insurance/Medicaid/Medicare #: ______________________________

Is this child's first eye exam? Yes: ______ No: ______
When was child's last eye exam? ______________________________
Has child worn glasses before: Yes: ______ No: ______ Contacts? Yes: ___ No: ___
Does child wear glasses now? Yes: ______ No: ______ Contacts? Yes: ___ No: ___

Has the child had any: *If Yes, please explain:*

Head injuries	Yes	No	______________________
Eye injuries	Yes	No	______________________
Eye diseases	Yes	No	______________________
Eye surgeries	Yes	No	______________________

Is child taking any medications? Yes . No
If Yes, please list medications: ______________________

Does child have:			*Does anyone in the family have:*		
Diabetes	Yes	No	Diabetes	Yes	No
Hypertension	Yes	No	Hypertension	Yes	No
Heart trouble	Yes	No	Heart trouble	Yes	No
Thyroid trouble	Yes	No	Thyroid trouble	Yes	No
Asthma	Yes	No	Asthma	Yes	No
Allergies	Yes	No	Glaucoma	Yes	No
Sinus problems	Yes	No	Cataracts	Yes	No
Arthritis	Yes	No	Amblyopia (Lazy Eye)	Yes	No
Other: ______________			Eye turns	Yes	No
			Other: ______________		

Has child complained about any of the following problems?

Blur at a distance	Yes	No	Blur at near objects	Yes	No
Double vision	Yes	No	Eye pain	Yes	No
Headaches	Yes	No	Eye strain	Yes	No
Difficulty reading	Yes	No	Flashes of light	Yes	No
Itching eyes	Yes	No	Tearing	Yes	No

Does your child sit very close to the television and/or computer? Yes No
Does your child receive optometry services elsewhere? Yes No
If Yes, please provide name of doctor: ______________________ and location of services: ______________________.

I hereby give my consent/permission to Head Start to transport my child to the IHS Optometry Clinic for a complete eye exam.

______________________________ ______________________
(Signature of Parent/Guardian) **(Date)**

CHILD DENTAL FORM

(A Dental Exam is REQUIRED before child attends school)

Is child on Medicaid/CHIP? Yes [ ] No [ ] Please list number: ____________________

Child's Name:____________________________________ Health Record No. ____________

Date of Birth: ____________________ Community where you live: ______________________

Phone No. (Home) ________________ Work: ________________ Cell: __________________

Mailing Address: ____

____

PLEASE CHECK:	YES	NO
1. Does child have a toothache now?	[ ]	[ ]
2. Has child received medical care in the last 2 years?	[ ]	[ ]
3. Have child ever been hospitalized?	[ ]	[ ]
4. Has child taken medication in the the last 2 months?	[ ]	[ ]
5. Is child allergic to or made sick by any medication such as penicillin, aspirin or codeine?	[ ]	[ ]
6. Has child ever had a bleeding problem that needed medical treatment?	[ ]	[ ]
7. Does child have chest pains?	[ ]	[ ]
8. Do you have reason to believe that the child has been exposed to AIDS or HIV?	[ ]	[ ]
9. Does child or anyone in the family have diabetes?	[ ]	[ ]

Has child ever had any of the following?	Yes	No
10. Hepatitis	[ ]	[ ]
11. Heart murmur	[ ]	[ ]
12. Heart attack	[ ]	[ ]
13. High blood pressure	[ ]	[ ]
14. Rheumatic fever	[ ]	[ ]
15. Heart valve or pacemaker	[ ]	[ ]
16. Artificial joint	[ ]	[ ]
17. Anemia	[ ]	[ ]
18. Ulcers	[ ]	[ ]
19. TB or lung disease	[ ]	[ ]
20. Asthma	[ ]	[ ]
21. Sinus trouble	[ ]	[ ]
22. Cancer or tumors	[ ]	[ ]
23. Epilepsy or seizures	[ ]	[ ]
24. Arthritis/rheumatism	[ ]	[ ]
25. Blood transfusions	[ ]	[ ]
26. Kidney problems	[ ]	[ ]
27. Liver problems	[ ]	[ ]
28. Nervous or mental disorders	[ ]	[ ]

Does child have any disease, condition or problem not listed? Yes [ ] No [ ]
(If Yes, please list):____

Do you have any concerns about child receiving dental services? Yes [ ] No [ ]
(If Yes, please list): ____

IMPORTANT

The answers I have given are true to the best of my knowledge. I am indicating my consent for routine dental procedures such as x-rays, cleaning, fillings, crowns and local anesthesia by signing below. I give authorization for the Head Start staff to take my child to the tribal dental office for such procedures if I am unable to do so.

______________________________________ ____________________
Signature of Patient or Parental Consent) Date

______________________________________ ____________________
Signature of Dentist Date

CRST HEAD START RELEASE OF INFORMATION FORM

Purpose: To provide direct services to families in meeting basic family needs/concerns.

_____ ***YES*** **I give the CRST Head Start Program permission to release/obtain information with the understanding that the information will be used to assist my family in receiving services. I also understand that I will be an active partner in the process.**

_____ ***NO*** **I do not give permission for the CRST Head Start Program to assist my family in obtaining any services. My family's needs are being met at this time or I am able to obtain services on my own.**

Disabilities & Education:

Preschools (Dupree, Isabel, Timber Lake, Sunny Days, Other: ____________________)
Child Developmental Clinic (Services to infants and young children with special needs, referrals & screenings)
Title I (Jump Start Program)

Family Services:

BIA Social Services (includes GA)
Child Support Enforcement (SD Office of Child Support Enforcement, CRST Child Support Enforcement)
Domestic Violence (Sacred Heart Center & Family Violence Prevention)
Employment (CRST Personnel, Employment & Training, BIA Personnel, TERO, etc.)
Energy Assistance (LIHEAP, Weatherization/HIP, Moreau-Grand, The Main, etc.)
Four Bands Healing Center (Substance Abuse, Al-Anon, Ala-Teen, Co-Dependency, etc.)
Housing (CRST Housing Authority, Habitat for Humanity, Oti Kaga, Inc., Wheatridge/Prairie/Evergreen)
Legal Services (Dakota Plains, Public Defenders, Children's Court, Civil/Criminal)
Nutrition Services (Food Pantry, WIC, Food Distribution, etc.)
Sacred Heart Center (Domestic/Family Violence, clothing assistance, counseling, etc.)
Support Services (Emergency Assistance)
The Main (Heating Assistance, Direct Services-clothing, diapers, etc., After School Activities)

Health & Mental Health:

Counseling Services (Professional Consultation Services, CRST Counseling, Three Rivers, etc.)
Dental Program (dental work, etc.)
Diabetes (, Youth Diabetes Prevention, Diabetes Program)
Eagle Butte Family Horizon Health Center (Physicals/Immunizations)
Faith Clinic (physicals, immunizations)
Indian Health Service (Pediatrics, Field Health, Medical Records – Physicals and Immunizations)
Isabel Clinic (Physicals/Immunizations)
Optometry (Appointments for vision, glasses, contacts, exam results.)
West Dakota Health Center (Physicals/Immunizations)
State Department of Health (Immunizations)

Transition:

____ **I DO** ____ **I DO NOT** give permission for the CRST Head Start program to transfer my child's records to: (name of school): where my child will be attending Kindergarten for the SY 2020-2021

Publicity:

___ **I DO** ___ **I DO NOT** give my consent for the Head Start Program to use my child's photograph in the Head Start newsletter and the local media (*West River Eagle, Faith Independent and Timber Lake Topic);* and not on the internet.

If you have more than one child in Head Start, please list both children:

Child:________________________________ **DOB:** ____________
Child:________________________________ **DOB:** ____________

I understand that this form will be valid for one year from the date of my signature.

X______________________________ **X**________________

Signature of Parent/Guardian Date

CHEYENNE RIVER HEAD START PROGRAM
PHYSICAL EXAMINATION FORM
(Parents fill out top part of form)

Child's Name:_______________________________________ Sex:_____ Date of Birth:___________
Home Address:_______________________________________Home Ph#:__________ Cell: ___________

The following screening tests are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N" for normal, "S" for suspect or "A" for Atypical/Abnormal, respectively.

REQUIRED	DATE	RESULTS	OPTIONAL	DATE	RESULTS
Present Age		Yrs ___ Mos. ___	TB Test		
Height			Urinalysis		
Weight		***BMI is:**	Ova & Parasites		
Blood Pressure			Sickle Cell		
***Hematocrit/Hemoglobin**					
***Lead**					
Hearing		Type of Test:________________ Right:__________ Left:__________ Comments:			
Vision		Type of Test:________________ Right:__________ Left:__________ Comments:			

Physical Examination/Assessment	Normal	Abnormal	Comments:
General Appearance			
Posture/Gait			
Speech			
Head			
Skin			
Eyes			
1. External Aspect			
2. Optic Fundoscopic			
3. Cover Test			
Ears			
1. External & Canals			
2. Tympanic Membranes			
Nose, Mouth, Pharynx			
Teeth			
Heart			
Lungs			
Abdomen			
Genitalia			
Bones, Joints, Muscles			
Neurological/Social			
1. Gross Motor			**What immunizations were given, if any?**
2. Fine Motor			
3. Communication Skills			
4. Cognitive			
5. Self Help Skills			**Does child have Mongolian Spots? Yes___ No___**
6. Social Skills			**If Yes, describe where on body:**
Glands (lymphatic/thyroid)			____
Muscular Coordination			
Child up to date on immunizations/EPSDT? Yes / No			
General Statement on Child's Physical Status:			
Findings, Treatments, and Recommendations:			

Physician/Health Professional Signature:____ Date:______________

Vision Screening Consent Form

Your local Lions Club and KIDSIGHT South Dakota is offering a free vision screening to your child. The screening is approximately 85-90% effective in detecting potential vision problems. No physical contact is made with your child and no eye drops are required. For more information go to www.kidsightsd.org.

Child's Name:	**Date of Birth:**	○ Male ○ Female
Ethnicity: ○ Hispanic ○ White ○ Black ○ Native American ○ Asian ○ Other		

Parent/ Guardian Name:	**Phone:**
Address:	**Email:**

For Multiple Children Being Screened:

Child's Name:	**Date of Birth:**	○ Male ○ Female
Ethnicity: ○ Hispanic ○ White ○ Black ○ Native American ○ Asian ○ Other		

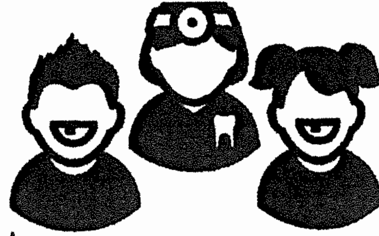
Child's Name:	**Date of Birth:**	○ Male ○ Female
Ethnicity: ○ Hispanic ○ White ○ Black ○ Native American ○ Asian ○ Other		

1. The information obtained from this vision screening is preliminary only, and does not constitute a complete exam or diagnosis of vision problems.
2. The Data obtained from this vision screening may be shared with entities participating in the vision screening i.e. school nurse, Head Start, daycare provider, SD Lions Foundation, etc. Results will be kept private and on file by the SD Lions Foundation including your child's name and date of birth.
3. I will receive the results of the screening through the Lions "KIDSIGHT" Preschool Vision Screening Program only if my child is being recommended for a full eye exam.
4. I understand I am responsible for arranging a complete eye exam if my child has been referred as a result of the screening.
5. I may receive communication by telephone or email if my child does not pass the vision screening for the purpose of evaluating the success of the program.
6. I will not hold the SD Lions Foundation accountable for any errors of commission, omission or another misdiagnosis.

_______________________________ Parent or Guardian Signature

_______________ Date

DELTA DENTAL



Parent Information

The Delta Dental Mobile Program is coming to your child's school!

Our Mobile Program team will visit your child's school this year to provide preventive dental care.

A dental hygienist will provide:

- teeth cleaning;
- sealant and fluoride treatments to prevent cavities;
- instruction to care for teeth at home; and
- a free toothbrush.

This care is provided at NO COST to the child or family. Sign up today!

To have your child receive this dental care, you must COMPLETE & SIGN the attached Patient Information and Permission Form.

Your child will not receive care unless the ENTIRE form is completed and includes your signature.

Healthy teeth are important!

A toothache can make it hard for a child to eat, sleep, and pay attention. That's why a child with good oral health will do better in school.

Cavities are almost 100% preventable. Let us help keep your child's smile healthy and happy.

Note: If your child already has a dental home and regular office visits (at least one a year), a visit with our team may not be necessary.

Delta Dental of South Dakota deltadentalsd.com Toll Free: (877) 841-1478 Fax: (605) 494-2578

MOBILE PROGRAM

Patient Information and Permission Form

General information

Patient information

Legal name ______________________

Age ________ Birth date (mm/dd/yyyy) ____/____/____

Sex ☐ Male ☐ Female

School attending ______________ Grade ______

Race
- ☐ White ☐ Asian ☐ Other
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Hawaiian or Other Pacific Islander
- ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Parent/guardian information

Name ______________________

Relation to patient ______________________

Home (mailing) address ______________________

City ______________ Zip ______

Home phone (______)________-________

Work phone (______)________-________

Cell phone (______)________-________

☐ Check here if you do not want to receive text messages.

Emergency contact information

Name ______________________

Relation to patient ______________________

Phone (______)________-________

Dental history

Dental visits should start at first tooth.

☐ Yes ☐ No Is this the patient's first dental visit?
If no, how long has it been?
☐ Less than 2 years ☐ More than 2 years

Past or current dentist's name ______________________

☐ Yes ☐ No Is the patient experiencing toothache/mouth pain/face swelling?

☐ Yes ☐ No Has the patient visited the ER/hospital for dental pain in the last year?

☐ Yes ☐ No Has dental pain caused you or your child to miss school and/or work in the last year?
☐ School ☐ Work ☐ Both

Medical history

Patient's current physician ______________________

Date of last medical exam (mm/yy) ______/______

☐ Yes ☐ No Is the patient taking any medications?
If yes, please list ______________________

☐ Yes ☐ No Does the patient have any allergies?
If yes, please list ______________________

☐ Yes ☐ No Does the patient have any special needs that would require special arrangements for dental care? e.g. autism
If yes, please explain ______________________

☐ Yes ☐ No Is the patient pregnant?

Does the patient have, or have they had, a history of the following:

- ☐ ADHD
- ☐ AIDS / HIV
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Birth defects
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Excessing bleeding
- ☐ Fainting
- ☐ Heart problems
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mono
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ Other ________

Please explain your answers: ______________________

Pg. 2

MOBILE PROGRAM

Patient Information and Permission Form

Patient behavior

☐ Yes ☐ No Does the patient brush daily?

☐ Yes ☐ No Does the patient drink soda pop or other sugar-sweetened drinks (Kool-Aid, fruit drink, sports drink) daily?

☐ Yes ☐ No Is the patient using tobacco or vaping products?

☐ Yes ☐ No Does anyone in the household use tobacco or vaping products?

Household information

Annual household income

☐ Less than $10,000 ☐ $10,000-20,000
☐ $20,000-30,000 ☐ More than $30,000

How many children age 21 or younger live in your household?

____

Insurance

Please check any that apply.

☐ No dental insurance

☐ Medicaid

Medicaid number ____________________

☐ Private DENTAL insurance (please provide copy of card)

____
Dental insurance name

____
Policy number

____
Group number

____
Dental insurance address

Insurance phone (_____) _____ - _____

____
Employer name

⚠ IMPORTANT – Permission to provide treatment

We cannot treat your child if form is not signed.

I, ____________________, as a legally responsible guardian of ____________________
Print parent/legal guardian name — Print child's name

give my permission for the dental services I have authorized below. Please note that preventive dental hygiene services alone, provided outside of a regular dental office, should not replace regular exams by a dentist. I have been offered and/or have read Delta Dental's HIPAA Notice of Privacy Practices available at southdakota.deltadental.com/privacy-and-policies/notice-of-privacy-practices/.

Each item needs to be answered in order to receive dental care.

☐ Yes ☐ No Preventive services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.

☐ Yes ☐ No Dentist exam (including dental x-rays)

☐ Yes ☐ No Restorative services: fillings, stainless steel crowns, pulpotomy. Local anesthetic may be used for these procedures.

☐ Yes ☐ No Silver diamine fluoride (decayed area of the tooth will be stained black permanently – please see attached for more information about this treatment)

☐ Yes ☐ No Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Local anesthetic may be used for these procedures.

☐ Yes ☐ No The use of nitrous oxide (laughing gas) may be used as deemed necessary.

➡ X ____________________ X ____ / ____ / ____
Parent/legal guardian signature — Date

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