SCHOOL-BASED ORAL HEALTH PROGRAM DENTAL CONSENT FORM AND RELEASE OF LIABILITY

Dear Parent or Guardian:

As part of the "Healthy Kids, Healthy Mind" initiative, the Chicago Department of Public Health and the Chicago Public School's SCHOOL - BASED ORAL HEALTH PROGRAM (the "PROGRAM"), licensed dentists will be coming to your child's school in the near future to provide a DENTAL EXAM /SCREENING, DENTAL CLEANING, GEL 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 teeth from DECAY. 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.

In consideration for your child's participation in the PROGRAM, and as evidenced by your signature below, you 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 you or to your child, for any and all losses, injuries, damages to you or your child, both known and unknown, foreseen and unforeseen, arising in connection with your child'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, 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.

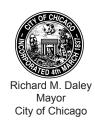
As evidenced by your signature below, you acknowledge that a licensed practitioner providing medical or dental care, treatment, diagnosis, or advice without charge on behalf of the City of Chicago Department of Public Health is not liable for civil damages resulting from his or her acts or omissions 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 with your child's school, the CPS Office of Specialized Services and the Illinois Department of Healthcare and Family Service, please complete and sign the Authorization Form that appears on the back of this letter. This signed consent form is valid the date that it is signed by the child's parent or guardian until August 31, 2011.

If you would like your chil	d to participate, p	please complete the belo	w information, and return	it to your c	child's school.	
(School Name)		(Classroom)	(Student ID N	umber)	(Phone)	
(Student Name)		(Date of Birth)	(Grade)		(Sex)	
(Home Address)			(Apartment N	umber)	(Zip Code)	
Hispanic (Please circle one)	Race: (I	Please circle one)				
Yes No	White	Black Asian / Pacif	ic Islander American Inc	lian/ Native	Alaskan	
MEDICAL INFORMATION:	Has your child e	ver had any of the following	g: YES or NO If YES: Ple	ase circle t	the appropriate conditio	n below
Diabetes	Epilepsy	Currently has He	eart Murmur	Rheumatio	c Fever or Rheumatic H	leart Disease
Asthma	Hepatitis	Blood Disorder/	Disease			
Is your child taking any med	lication? If YES, P	ease list medication:				
Does your child have any A	lergies? If YES, P	ease list Allergies:				
Any other medical related of	onditions? If YES,	Please list the conditions:				
MEDICAID / ALL KIDS: Do	oes your child part	cipate in: (Please circle)				
Free or Reduced Lunch	YES / NO	Medicaid / All Kids Y	ES / NO			
		If YES: Please provide N	Medicaid / All Kids Information	n:		
ID#	Case ID	#	Eligibility Pe	eriod :	thru	
As the parent or guardian of includes a dental exam/scre Quality Assurance exams. I that if I fail to sign this De	ening, dental clear authorize the prov	ning, gel or varnish fluoride ider dentist to use my child	e treatment, the application of d's or ward's Medicaid, ALL I	f dental sea (IDS numb	alant(s) if appropriate, a er for billing purposes o	and the receiving of only. I understand
Date:		Parent or gua	rdian signature:			

Please fill out and Sign the Authorization Form on the other side→

(Revised 06.30.10)

School-Based Oral Health Program Authorization Form For the Use and Disclosure of Protected Health Information



Child's Name :					
Address :					
Date of Birth :	School	School Name :			
	understand that I am giving my authoriotected health information (PHI), as de		ity of Chicago Department of Public Health illowing person(s) or organization(s):		
My child's school, the Chicago Publ	lic Schools Office of Specialized Service	ces and the State of Illinois Healthcare	e and Family Service Office.		
I specifically authorize the use and	disclosure of the following PHI:				
Information relating to PROGRAM of	dental services provided to my child.				
This authorization is valid the date t	that it is signed by the child's parent or	guardian until August 31, 2011.			
fice of Specialized Services as spec		at such a revocation will not have any	hool, and the Chicago Public Schools Of- effect on any information already used or		
Notice to the City:	Notice to the School	Notice to State of Illinois:	Notice to CPS Office of Specialized Services		
City of Chicago – Department of Public Health 333 S. State, 2nd floor Chicago, Illinois 60604 Attn: Privacy Officer	Notice to the School's Principal	Healthcare and Family Service 201 South Grand Avenue East Springfield, Illinois 62763	Chicago Public Schools Office of Specialized Services – 8th Floor 125 South Street Chicago, Illinois 60603 Fax: 773-553-1881		
no longer be protected by the Healt	al that the information disclosed pursual that the information disclosed pursual Insurance Portability and Accountab	ility Act.	ct to redisclosure by the recipient and will		
	provider nor the City of Chicago Depar uthorization, unless the treatment is re		reatment, payment, enrollment or eligibility		
I understand that I have the right to	be provided with a copy of this signed	authorization form.			
Signature of Parent or Guard	dian	Date			
Printed Name of Parent or G	Suardian	Relationship to Child			

Please fill out and Sign the Consent Form on the other side \rightarrow



Authorization –dental program Final. (rev.06.30.10)