James River Dental Center: (434) 847-4691
239 Trojan Lane, Madison Heights, VA 24572

Bedford Community Dental Center: (540) 425 -7914
600 Bedford Ave., Bedford, VA 24523

Lynchburg Women's and Pediatric Health Services, (434) 455- 3260
2402 Atherholt Road, Lynchburg, VA 24501

DENTAL SCHOOL EXAMINATIONS REQUEST FORM

Attention: Parents of Pre-K through Fifth Grade Students
who are covered under FAMIS or Medicaid

In order to receive this service, parents must give their consent for confidential information regarding free lunch eligibility, dental insurance information or FAMIS/Medicaid numbers to be released. By signing below, you are giving consent for the release of this information.

(Note: If you do not have FAMIS/Medicaid or other dental insurance, this dental examination is available to you for $25)

Student Name: ____
(PLEASE PRINT)

School Name: ______________________ Grade: _____ Teacher: ______________

Student receives free/reduced lunch: ________ Yes ________ No

My child does not have insurance. I wish to pay $25 by: ___Cash ___Money Order (NO CHECKS)

I request that confidential information regarding free/reduced lunches, FAMIS or Medicaid only be released for the purpose of qualifying my child for a dental examination and cleaning.

Parent Name: ______________________________
(PLEASE PRINT)

Parent Name: ______________________________ Date: ______________
(SIGNATURE)

PARENTS/GUARDIANS MUST COMPLETE AND SIGN THE
MEDICAL INFORMATION FORM
ON REVERSE SIDE OF THIS DOCUMENT
(Return completed form to Nurse or Child's Teacher)

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STUDENT INFORMATION

STUDENT NAME: ____________________ BIRTH DATE: ______________ SEX: ________

STUDENT'S SOC. SEC. #: ____________________ RACE: ______________

ADDRESS: ____________________ CITY: ______________ ZIP: ________

PARENT/GUARDIAN: ____________________ CONTACT PHONE #: ______________

STUDENT'S FAMIS/MEDICAID/INSURANCE NUMBER: ____________________

OTHER DENTAL INSURANCE CO.: ____________________

POLICY HOLDER NAME: ____________________ POLICY NUMBER: ______________

STUDENT'S MEDICAL HISTORY

DOES STUDENT HAVE (NOW, OR IN THE PAST) ANY OF THE FOLLOWING CONDITIONS?

☐ HEART MURMUR	☐ HEART DISEASE/DEFECT	☐ BLEEDING DISORDER	☐ RHEUMATIC FEVER
☐ SCARLET FEVER	☐ LIVER PROBLEMS/JAUNDICE	☐ SICKLE CELL ANEMIA	☐ DIABETES/SUGAR
☐ HEPATITIS (A-B-C)	☐ ARTIFICIAL HEART VALVE	☐ EPILEPSY/SEIZURES	☐ CANCER/TUMOR
☐ CEREBRAL PALSY	☐ DEVELOPMENTAL DELAY	☐ AUTISM/ASPERGERS	☐ ADD/ADHD
☐ HIV/AIDS	☐ OTHER ____________________		☐ AUTISM

LIST STUDENT'S MEDICATIONS (IF ANY) AND REASON FOR TAKING (attach additional sheets if necessary):

____

IS STUDENT ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? ____________________

____

INFORMED CONSENT AND DEEMED CONSENT

I authorize James River Dental Center/Bedford Community Dental Center/Lynchburg Women's and Pediatric Health Services to perform on my child a dental examination, cleaning, fluoride treatment and oral hygiene instruction as deemed necessary by the dentist. I understand that I can discuss any concerns I have with the Dental Center. I understand the above information is necessary to provide my child with dental care in a professional and safe manner. I have answered all the questions to the best of my knowledge.

If one of our health care professional, workers or employees should be directly exposed to your child's blood or body fluids in a way that may transmit disease, your child's blood will be tested for infection with Human Immunodeficiency virus (HIV,AIDS virus) and for the presence of the Hepatitis B and Hepatitis C viruses. A physician or other healthcare provider will tell you and that person the result of the test and provide counseling, if necessary.

If your child should be directly exposed to the blood or body fluids of one of our healthcare professional, workers, or employees, in a way that may transmit disease, that person's blood will be tested for infection with Human Immunodeficiency virus (HIV,AIDS virus) and for the presence of the Hepatitis B and Hepatitis C viruses. A physician or other healthcare provider will tell you and that person the result of the test and provide counseling, if necessary.

PARENT NAME: ______________________________ Date: ______________

(SIGNATURE)