Give Kids a Smile Day 2010
National Day: February 5th

United Way of North Central Iowa and North Iowa Community Action Organization (NICAO) have teamed up to provide Give Kids a Smile Day in north central Iowa.

Our unique version of this program entails school screenings by Peggy Funk, dental hygienist, NICAO. During this screening the selected students are given a dental screening, fluoride varnish and dental x-rays. The x-rays are then given to the participating dentists to help determine which uninsured/underinsured children need further treatment and should be seen on Give Kids a Smile Day.

We want to make this an easy and enjoyable process for you, but to help make things run smoothly we will need a few items from you (attached):

□ Contract
□ Participation Sheet
□ Participant Selection
□ Participant Summary
□ Transportation Refund

We need your help making this day a success! Please consider being a part of this great program in 2010.

Sincerely,

Regional Coordinators
United Way of North Central Iowa

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LIVE UNITED™

United Way of North Central Iowa

600 1st Street NW, Ste 102 • Mason City, IA 50401 • Phone: (641) 423-1774
Fax: (641) 423-2221

SCHOOL CONTRACT

School: ____

Contact Name: ____

Title: ____

Whereas, my commitment is to the health and well-being of children, I hereby pledge to do my part to:

- Help to create a safe and friendly process for children
- Assist with transportation of participants - if possible
- Ensure all student forms are filled out
- Have all forms returned from students 2-3 days prior to the screening date
- Keep open communication with United Way Coordinator
- Assist in selecting the appropriate kids for the process
- Report any requirements/regulations for you to participate to United Way upon sign up
- Assist in securing a space for dental screenings to be done at the school
- Submit all paperwork to United Way of North Central Iowa as soon as possible (see attached forms for submittal)

Signature: ______________________________ Date: ______________

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PARTICIPATION SHEET

School:

Contact name: Title:

Address:

Phone number: Fax number:

Requested date and time of screening:

How many kids do you *expect* to participate:

How many kids (school wide) do you have participating in free and reduced lunch:

What grades will you be selecting kids from:

If more than one school building we prefer the screening take place in 1 location is this something that can be accommodated:

Will you have a room available for the screening:

Will you be able to assist with transportation (United Way will refund you):

If yes, will you be willing to transport the kids to a different town or county if no local dentist participates:

Please list any other requirements/regulations you have concerning Give Kids a Smile Day:

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PARTICIPANT SUMMARY

Please fill out the information below based on the forms you receive back from the students.

Date of screening: ________________________

Time of screening: ________________________

Number of Kids to be screened: ________________________

Number of uninsured (no insurance): ________________________

Number of underinsured (title IX or Hawk-i): ________________________

What is the age range of kids to be screened: ________________________

Please return this form with the completed applications for participation **at least 3 days before** the screening date.

We need to bring a lot of supplies with us for these screenings, this information will help us be fully prepared to screen your students. Having **all** of the forms returned by this deadline will help to make the process run smoothly.

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PARTICIPANT SELECTION

We are constantly looking for ways to improve the Give Kids a Smile Program and could use your help! We are starting to gather more information on how our participating schools are selecting their Give Kids a Smile participants.

This data will help us know how each of you are selecting participants and help us give ideas to schools new to the process.

Please give a short description of the method you use to selected students for the

Give Kids a Smile Program:____

____

____

____

____

Please list any other information you feel would be helpful or any comments you

may have about the Give Kids a Smile Program:_____________________________

____

____

____

____

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TRANSPORTATION REFUND

Please fill out the sheet below to be reimbursed for your travel costs.

School:____

Contact Name:____________________________________

Address:____

List the type of costs below	Amount spent
____________________	________
____________________	________
____________________	________
Total Refund Requested:	$________

Please return this form as soon as possible after your selected Give Kids a Smile Day to:

United Way of North Central Iowa
Give Kids a Smile
600 1st Street NW, Ste 102
Mason City, IA 50401
Fax: 641-423-2221

Thank you so much for your participation! We could not have done it without **YOU!**

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United Way of North Central Iowa

600 1st Street NW, Ste 102 • Mason City, IA 50401 • Phone: (641) 423-1774
Fax: (641) 423-2221

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Dear Parent or Guardian,

Your child has a chance to participate in Give Kids a Smile Day, an event that will take place this spring (more specific information will be provided later).

It is often difficult for families to afford the rising cost of healthcare, and many insurance plans do not include dental coverage. Unfortunately, this means that some children do not receive the dental care they need.

Give Kids a Smile is an annual event that provides children with dental care at no charge. Local dentists have volunteered their dental services and will provide these services to participating children with dental care needs. This care will be given at no cost and transportation will be provided through the school system and United Way of North Central Iowa.

Screenings and dental x-rays will be done by North Iowa Community Action Organization to determine which children have the greatest need.

If you are interested in obtaining dental care for your child in 2010, please complete ALL of the attached forms and return them to your child's school as soon as possible.

Thank you and we look forward to working with you and your child.

Please feel free to contact United Way or your school nurse if you have any questions.

Sincerely,

United Way of North Central Iowa
641-423-1774
877-428-8962

ADA American Dental Association®

North Iowa Community Action Organization
DENTAL CONSENT FORM

Child's name		Age	Date of Birth
Address:	Phone:		
Child's physician:	Child's dentist:		
Medicaid ID number:			

Please check all that apply:

_____ **YES**, I give permission for my child to receive a dental screening and fluoride varnish application. (In order for fluoride to be applied a screening must be performed.)

_____ **YES,** I give permission for my child to receive a dental screening.

_____ **Yes**, I give permission for my child to receive digital x-rays, if they are necessary, which will be taken by a Licensed Dental Hygienist.

Please answer the following questions:

1. Is your child currently under a physician's care? Yes No
2. Is your child currently taking any medications? Yes No
3. Does your child have any allergies? Yes No

Please explain any YES answers:

Do you have any concerns or questions about your child's mouth or teeth?________________________
How often does your child brush his/her teeth?____

Please answer the following questions.

1. Does your child have a regular dentist? _______ Yes _____ No
2. If yes, does your child see that dentist at least once a year? _______ Yes _____ No
3. My child's most recent dentist visit was within the past: (please check **one**)

_______ 6 months _______ 1 year _______ 3 years _______ 5 years _______ Has never seen a dentist

4. How do you pay for your child's dental care? (please check **one**)

_____ Self _____ Medicaid/Title XIX _____ ***hawk-i*** _____ Private dental insurance _____ Other

I understand that this consent is valid for one (1) year.

- I understand that these services are provided under the Iowa Department of Public Health and NICAO'S Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health and North Iowa Community Action Organization.
- I understand that the information from these records may be shared with the Iowa Department of Public Health (Bureaus of Family Health or Oral Health), the Iowa Department of Human Services, or designee.
- I understand that this screening does not take the place of a regular check-up by a dentist.
- I understand that any x-rays taken will be viewed by NICAO's Dental Director or advisory committee for examination.

____
Parent/Guardian Signature Date

Give Kids A Smile Day

PATIENT INFORMATION

First ___________________________________ MI ______ Last ____

Date of Birth ____/____/______ Sex _________

Address ____
Street City ZIP

Phone _(______)__________-_____________ Emergency Contact ____________________________________

PATIENT MEDICAL HISTORY

Asthma	Yes	No	Pneumonia	Yes	No
Heart Murmur	Yes	No	Headache/Migraine	Yes	No
Diabetes	Yes	No	Chicken Pox	Yes	No
Mononucleosis	Yes	No	Rheumatic Fever	Yes	No
Congenital Heart Disease	Yes	No	High Blood Pressure	Yes	No
Rheumatic Heart Disease	Yes	No	Low Blood Pressure	Yes	No
Bleeding Problems	Yes	No	Fainting Seizures	Yes	No
Kidney Disease	Yes	No	Epilepsy/Convulsions	Yes	No
Thyroid Problems	Yes	No	Leukemia	Yes	No
Anemia	Yes	No	Frequently Tired	Yes	No
Cancer	Yes	No	AIDS or HIV	Yes	No
Hepatitis/Jaundice	Yes	No	Arthritis	Yes	No
Stomach Troubles/Ulcers	Yes	No	Sexually Transmitted Disease	Yes	No
Hay Fever/Allergies	Yes	No	Chest Pains	Yes	No
Liver Disease	Yes	No	Tuberculosis	Yes	No
Mitral Valve Prolapse	Yes	No	Recent Weight Loss	Yes	No
Respiratory Problems	Yes	No	Disabilities List:	Yes	No

Physician_____________________________ Office Phone__________________ Date of last exam____________

Please list all ALLERGIES/SENSITIVITIES/DRUG REACTIONS and Reaction Type: ________________________

____

Is your child taking any medications now? If yes, please list ____

Is your child under medical treatment right now? If yes, please explain ________________________

____

Does your child use tobacco? __________ Does your child use controlled substances? _____________

Does your child wear contact lenses? ______________________

Has your child had any other serious illness or operation?__________ If yes, please explain: _____________

____

Is there anything else we should know about the health of your child? Please List: _____________________

____

PATIENT DENTAL HISTORY

Name of previous dentist and location ____

Date of last exam ____

Does your child's gums bleed while brushing or flossing?	Yes	No
Are your child's teeth sensitive to hot or cold liquids or food?	Yes	No
Are your child's teeth sensitive to sweet or sour liquids or food?	Yes	No
Does your child feel pain to any of his/her teeth?	Yes	No
Does your child have any sores or lumps in or near the mouth?	Yes	No
Has your child had any head, neck or jaw injuries?	Yes	No
Has your child experienced any of the following problems in the jaw:		
Clicking?	Yes	No
Pain (joint, ear or side of face)?	Yes	No
Difficulty in opening or closing?	Yes	No
Difficulty in chewing?	Yes	No
Does your child have frequent headaches?	Yes	No
Does your child clench or grind his/her teeth?	Yes	No
Does your child bite his/her lips or cheeks frequently?	Yes	No
Have you ever received oral hygiene instructions regarding the care of your child's teeth and gums?	Yes	No
Does your child like his/her smile?	Yes	No

I give consent for my child to participate in Give Kids A Smile Day program conducted by the North Central District Dental Society, North Iowa Community Action Organization and United Way of North Central Iowa. In addition, I agree to share my child's dental information with these organizations in order for my child to receive the necessary follow-up dental care.

Name of Parent/Guardian (Printed)____

Signature____ Date___________________

ADA American Dental Association®

WAIVER AND RELEASE

In consideration of the free dental services received on the date signed below, I, for my child, do hereby waive and release the dentist treating my child (as well as any persons acting on his or her behalf, such as those volunteering at the dentist's office) from all claims of liability arising out of my acceptance of such free care, including, but not limited to, medical or dental care or advice.

Services being provided include a dental x-ray, dental examination, cleaning, and fluoride treatment. Additional services may be provided if deemed necessary by the dentist and/or persons acting on his or her behalf.

The dentists participating in Give Kids a Smile are available to us for this one-time promotion and not on a regular basis. The free services that will be provided do not constitute acceptance of the patient(s) into the dentist's practice.

The dentist and staff participating in Give Kids a Smile are volunteering their time and expertise to make this a positive experience for my child.

My child may or may not be eligible for follow-up treatment. I consent to any other follow-up treatment to be provided by a referring dentist or specialist and further waive and release any such follow-up dentists (or any persons acting on their behalf, such as those volunteering at his or her office) from all claims of liability arising out of my acceptance of such free care, including, but not limited to, medical or dental care or advice.

I give my permission for a photographer and/or other news media personnel to take pictures of my child. I understand that these pictures and/or film and/or interviews may be published in newspapers, may be used on radio or television, and may be shown to community groups.

I hereby authorize the release of all dental/medical records from the Give Kids a Smile program to the dentist(s) that will treat my child.

I have read (or have had read to me), understand, and agree to all of the above.

Patient Name ____

Parent/Guardian Name (please print) __________________________________

Parent/Guardian Signature ________________________________**Date**______