SKIPPY
San Juan Kids Cavity Prevention Program

SKIPPY+ Enrollment Form

You spoke and we listened! Skippy, now Skippy+, is new and improved. Still an evidence-based cavity prevention program, Skippy+ has new services for children grades Preschool-12th. We are now providing x-rays, restorative care and exam by a dentist. Additionally, we will offer clinics locally for fillings as needed, helping enhance and maintain the overall health of your child.

Tri-County Health Network has been providing Skippy for more than 8 years in elementary schools throughout Montrose, Ouray, and San Miguel counties. We have held 100+ Skippy clinics providing more than 5,000 treatments to local children.

Skippy is effective! For children who routinely attend Skippy, the percentage of children with untreated decay has been reduced to 20%, **9% below the national average**.

If your child does not have a dentist that he/she sees for regular checkups, then Skippy is for you!

Services Provided: If your child participates in Skippy+, we will provide the following services onsite at the school

- Take x-ray images
- Clean your child's teeth
- Apply fluoride to your child's teeth
- Dental exam performed **by a dentist**
- Seal your child's permanent teeth, as necessary
- Teach your child how to brush properly
- Provide free toothbrush and toothpaste
- Provide you a report about your child's oral health
- Referral to our follow up clinic for interim therpeutic restortation (ITR) and fillings, if needed
- Health insurance enrollment

Cost:
- Skippy+ is offered at no out-of-pocket costs to all families.
- However if you have Medicaid, CHP+, or private insurance, we will bill for services just like any other dentist.

Risk:
- The materials used and dental care provided in the Skippy+ program are the same as those in dental office.
- Dental care may have risks that are rare and minimal.
- Dental hygienists provide the care in partnership with a dentist who follow standard safety procedures that include wearing latex free gloves, facemasks and eye shields.

Privacy Policy:
- Information collected in this program will be kept private, unless required by law or to bill your insurance, and will be shared only within the Skippy+ program.
- If your child does not have health insurance our Navigators will contact you to offer help in getting coverage.

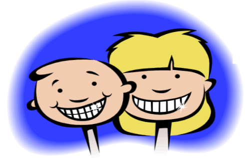
Withdrawal:
- Participation is voluntary; your child does not have to participate in Skippy+.
- The consent is valid for the entire school year, both fall and spring semesters, unless revoked.

Rights:
- Ask questions and have them answered to your satisfaction before and after signing the consent form.
- If you would like further information or have questions contact TCHNetwork at 970-708-7096.

***To enroll your child in this program, please:**
1. Complete and sign the "Health History Form"
2. Return the form to your school administration

SAN JUAN KIDS CAVITY PREVENTION PROGRAM (SKIPPY+)

Health History/Consent Form



CHILD'S PERSONAL INFORMATION

First Name: ________ Middle Initial: __

Last Name: ________

School: ________

Grade: __ Birthdate: __ / __ / ____ Male O Female O

Parent/Guardian First Name: ________

Parent/Guardian Last Name: ________

Home Phone: (___) ___ - ____ Cell: (___) ___ - ____

Address: ________

City: ________ State: __

Zip: _____

Email: ________

Language spoken at home: English O Spanish O Other O

Child's Race/Ethnicity: (check ALL that apply)

Black/African American O American Indian/Alaskan Native O Asian O Native Hawaiian or other Pacific Islander O White O

Hispanic or Latino O Not Hispanic or Latino O I do not wish to answer O

CHILD'S Health History

1. Has your child ever had serious health problems? YES O NO O If yes, for what? ________
2. Is your child under a doctor's care now? YES O NO O If yes, for what? ________
3. Please mark any illness or condition your child has EVER had:

   Epilepsy O Asthma O Heart Murmur O Convulsions/Seizures O Diabetes O

4. Is your child taking any medications at this time? YES O NO O If yes, for what? ________
5. Is your child allergic to latex? YES O NO O
6. Does your child have a dentist? YES O NO O

Dentist Name: ________

7. Do you need help finding a dentist? YES O NO O
8. Date last seen by a dentist: __ / __ / ____
9. Is there anything you like to tell us about your child regarding his/her dental experience? YES O NO O If yes, please explain: ________
10. Is your child eligible for free or reduced lunch? YES O NO O

Questions please call TCHNetwork at 970.708.7096

SKIPPY ID # _____

PAYMENT INFORMATION - YOU MUST COMPLETE AND SIGN AT BOTTOM

If you have Dental Insurance, Medicaid or CHP+ we will bill for services. If your child currenty receives dental care with a dentist, participation in Skippy is a duplication of those services and can result in denied insurance coverage for dental care.

Does your child have health insurance? YES ○ NO ○

Carrier Name:

Does your child have Medicaid? YES ○ NO ○ **If yes, Medicaid ID #*:**

Does your child have CHP+? YES ○ NO ○ **If yes, CHP+ ID #*:**

If you do not know your child's Medicaid/CHP+ ID# provide your child's Social Security#: - -

Does your child have dental insurance? YES ○ NO ○ **If yes complete the information below**

Name of Dental Insurance Co:

Phone #: ( ) -

Dental Insurance Billing Address:

City: State: Zip:

Subscriber/Policyholder First Name:

Last Name:

Male ○ Female ○ Birth Date: / /

Plan/Group #:

Subscriber ID#:

Employer Name:

Employer Address:

City: State: Zip:

CONSENT: The information on this page and the health history are correct to the best of my knowledge. I agree and authorize Tri-County Health Network's (TCHN) licensed dentist and dental hygenists to perform the above stated dental services as needed. I further understand that for the sustainability of the program, my insurance will be billed, if applicable. I request and authorize the release of any information on this form and acquired in the course of treatment for payment & referral purpose as deemed necessary by TCHN. I also authorize TCHN to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to TCHN, as applicable. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to TCHN.

Parent/Guardian Signature:______________________ Date: / /

Print Name:______________________ Phone: ( ) -

THIS CONSENT WILL BE VALID FOR ENTIRE SCHOOL YEAR UNLESS REVOKED

Please return this form to the school no later than 2 weeks before Skippy+ clinic

SKIPPY ID #

56311