Somali

BURLINGTON SCHOOL DISTRICT

Pre-K thru 5th Grade

School-Based Dental Center

Medical/Dental History Form

community health centers OF BURLINGTON

6 Archibald St., Burlington, VT 05401 ■ IAA Tel: 658-4869 ■ Tel: 652-1050 ■ Fax: 652-1056

1. The Community Health Centers of Burlington (CHCB) offers a great kid's School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School, 6 Archibald Street, Burlington.
2. All children who are Burlington School District students or siblings of students, who are enrolled in Medicaid, Dr. Dynasaur or are low-income and uninsured AND have not seen a dentist in the past year, are welcome. If you are low-income and uninsured, CHCB will help you meet with our Patient Support Services staff to apply for programs and/or our Sliding-Fee Scale Program.
3. Just fill out this form and sign it (read the back for translation if needed) and send it back to the school. If you need help with this process, CHCB will help you fill out the form. Please contact your school nurse, school liaison, or CHCB's Dental Center at 652-1050 or 658-4869. Please check box that applies.

Once your child is signed up, the school and the Community Health Centers will take care of everything else for you. If your child does not attend the Integrated Arts Academy at H.O. Wheeler, transportation can be arranged. Remember, parents are always invited to dental appointments, too. Dental care for your child has never been so easy!

Please make sure you fill out the form **completely** and **sign it on each page.**
Each child needs a registration form. For another form, just call the Integrated Arts Academy at 658-4869 or CHCB's Dental Center's main telephone number 652-1050.

Today's Date ____/____/____ School Child Attends: _____

Child's Name: _____ _____ _____ **Child's Date of Birth:** __/ ____/ ___
(Last) (First) (MI)

Child's Social Security Number: ____/____/____ **Primary Language:** _____

Street Address: _____ City _____ State _____ Zip Code _____

Name of Child's Physician: _____ Phone number _____ Last Visit _____

Name of Child's Dentist: _____ Phone number _____ Last Visit _____

Race	Gender	Sexual Orientation	Legal Sex	Ethnicity/ Ethnic Origin
☐ African-American	☐ Male	☐ Lesbian or Gay	☐ Male	☐ Hispanic
☐ Asian-American	☐ Female	☐ Straight/Heterosexual	☐ Female	☐ Non-Hispanic
☐ Caucasian/White	☐ Transgender Male	☐ Bisexual		
☐ Native American	☐ Transgender Female	☐ Something Else		
☐ Pacific Islander	☐ Other	☐ Don't Know		
☐ Multi-Racial	☐ Do Not Wish To Report	☐ Do Not Wish To Report		

Parent/Guardian Information

Name of Person Legally Responsible for Child: _____ Relationship: _____

Home # _____ Work # _____ Cell # _____ Email: _____

Alternate Contact Person: _____ Home # _____ Work # _____

Cell # _____ Relationship: _____ Email: _____

Insurance Information

Does your child have Medicaid or **NO** insurance? Please explain.

_____

☐ **Dr. Dynasaur/Medicaid Number #** _____ ☐ **No Dental Insurance**

_____
(Signature of parent/guardian) (Date)

☐ Interpretation or Translation offered and understood.

_____
(Signature of person completing form if not parent/guardian) (Contact number)

BURLINGTON SCHOOL DISTRICT

Barbaarinta ilaa Fasalka 5aad

Xarunta Ilkaha ee Dugsiga

Foomka Taariikhda Caafimaadka/Ilkaha

community health centers OF BURLINGTON

617RiversideAvenue ■Burlington,VT05401■TelNo.802-652-1050

1. XarumahaCaafimaadka Bulshada ee Burlington (CHCB) waxay ku bixisaa Xarunta Ilkaha ee Dugsiga ee ilme fiican Integrated Arts Academy oo ku yaala H.O. Wheeler School,6 ArchibaldStreet,Burlington.
2. Dhammaan carruurta ah ardayda Degmo Dugsiyeedka Burlington ama walaalaha ardayda, kuwaasi oo qoran Medicaid, Dr Dynasaur ama ah qaar sabool ah oo bilaa caymis ah OO aan arag dhakhtar ilkeed sannadkii hore, ayaa la soodhaweynayaa. Haddii aad sabool tahay caymisna aanad lahayn, waxaanu kaa caawin doonaa inaad la kulanto shaqaalahayaga Mutaysiga Adeegga si aad u dalbato barnaamijyada iyo/ama Barnaamijka Qiyaasta Khidmadda Isla Beddesha Haynta Macmiilka.
3. Kaliya buuxi foomkan oo saxeex (ka akhri dhabarka tarjumaadda haddii loo baahdo) oo dib ugu soo dir dugsiga.Haddii aad caawimo u baahan tahay arrinkan, waxaanu kaa caawin doonaa buuxinta foomka. Fadlan la xidhiidh kalkaalisada dugsigaaga, xidhiidhiyaha dugsiga, ama Xarunta Ilkaha CHCB 652-1050 or658-4869. Fadlan sax saar sanduuqa khuseeya.

Marka ilmahaaga la qoro, dugsiga iyo Xarumaha Caafimaadka Bulshada ayaa kuu daryeeli doona wax kasta. Haddii ilmahaagu aanu dhigan Integrated Arts Academy oo ku yaala H.O. Wheeler, gaadiid ayaa loo qabanqaabin karaa. Xasuusnaw, waalidiinta waxa had iyo jeer lagu martiqaadayaa ballamaha ilkeed, sidoo kale. Daryeelka ilkaha ee ilmahaagu waligood ma noqon qaar fudud!

Fadlan hubi inaad buuxiso foomka **si dhammaystiran** oo **aad saxeexdo bog kasta**.
Ilme kastaawuxuu u baahan yahay foom diiwaangalin. Foom kale si aad u hesho, kaliya wac IntegratedArtsAcademy 658-4869ama lambarka taleefanka dhexe ee Xarunta Ilkaha CHCB652-1050.

Taar. Maanta_____/____/_____ Dugsiga Ilmuhu Dhigto:_____

Magaca Ilmaha:_____ _____ _____**Taar. Dhalashada Ilmaha:**/_____/____
(Last) (First) (MI)

Lambrka Sooshiyaal Sikiyuuriti ee Ilmaha:_____/_____/_____ **Luuqadda Koowaad:** _____

Cinwaanka Jidka:_____Magalada._____Gobolka____ZipCode_____

Magaca Dhakhtarka Ilmaha:_____ Lam. taleefanka _____Booqashadii u Dambaysay_____

Magac Dhakharka Ilmaha:_____ Lam. Taleefanka_____Booqashadii u Dambaysay_____

Qolada	**Jinsgiga**	**Doorashada Jinsiga**	**Jinsiga Sharciga ah**	**Isirka/Asalka Isirka**
☐ Afrikaan Maraykan	☐ Lab	☐ Khaniisad ama Khaniis	☐ Lab	☐ Hisbaanik
☐ Eeshiyaan Maraykan	☐ Dheddig	☐ Toosan	☐ Dheddige	☐ Hisbaanik Ahayn
☐ Kawkaashiyaan/Caddaan	☐ Labka Labeebka ah	☐ Lab-dheddig		
☐ Dhalad Maraykan ah	☐ Dheddigga Labeebka ah	☐ Wax kale		
☐ Basifik Ayslander	☐ Mid kale	☐ Ma aqaan		
☐ Iska Dhal	☐ Ma Doonayo inaan Sheego	☐ Ma Doonayo inaan Sheego		

Macluumaadka Waalidka/Wakiilka

Magaca Qofka Sharciyan ka Masuulka ah Ilmaha:_____Xidhiidhka: _____
Guriga_____# Shaqada_____# Mobilka_____Iimaylka:_____

Qof Kale ee lala Xidhiidhayo:_____ #Guriga_____ #Shaqada_____
#Mobilka_____ Xidhiidhka:_____Iimaylka:_____

Macluumaadka Caymiska Ilmahaagu ma leeyahay ama**BILAA**caymis? Fadlan sharrax.

☐ **Lambarka Dr.Dynasaur/Medicaid#** _____ ☐**Maya Caymis Ilkeed**

(Saxeexa waalidka/wakiilka) (Taariikhda)

☐ Tarjumaadda Hadalka ama Qoraalka la bixiyey ee la fahmay.

(Saxeexa qofka dhammaystiraya foomkan Hadduuna ahayn waalidka/wakiilka) (Lambarka lala xidhiidhayo)

community health centers OF BURLINGTON

Child's Name: _____ **Child's Date of Birth:** _____
(Last) (First) (MI)

Medical/Dental History Form

Your child's overall health, as well as any medications that your child takes could have an important impact on your child's medical/dental care.

Please answer each of the following questions completely.

Have you ever been told your child needs antibiotics prior to dental work? ☐Yes ☐No
Has your child had any trouble with previous dental work? ☐Yes ☐No

If yes, please explain: _____

Medical History

Does your child have any of the following diseases or problems? If **yes** please check the corresponding box:

YES	NO		YES	NO	
☐	☐	Asthma	☐	☐	Convulsions/Epilepsy
☐	☐	Cancer	☐	☐	Tuberculosis
☐	☐	Hepatitis	☐	☐	Abnormal Bleeding
☐	☐	HIV/AIDS	☐	☐	Sinus Trouble
☐	☐	Hemophilia	☐	☐	Anemia
☐	☐	Diabetes	☐	☐	Rheumatic Fever
☐	☐	Allergies	☐	☐	Handicap/Disability
☐	☐	Congenital Heart Defect	☐	☐	Heart Murmur Antibiotic needed per Dr. _____

Any other medical problems not listed (Please Explain):

_____

_____

List any medications your child is taking (Please include prescription and non prescription drugs)

1._____ 3._____

2._____ 4._____

Is your child allergic to or had a bad reaction to any of the following?

YES	NO		YES	NO	
☐	☐	Local anesthetics (Novocain)	☐	☐	Penicillin or other antibiotics
☐	☐	Latex	☐	☐	Sedatives, barbiturates, or sleeping pills
☐	☐	Aspirin	☐	☐	Iodine
☐	☐	Codeine or other narcotics	☐	☐	Other:

Please sign below to ensure proper dental/ health care for your child. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to notify the healthcare provider office of any changes in my child's medical history. I also authorize treatment such as radiographs, routine check-ups (including fillings and extractions) and fluoride to be given to my child as needed at each dental visit.

_____ _____
(Signature of parent/guardian) (Date) (Signature of dentist reviewing history) (Date)

☐ Interpretation or Translation offered and understood.

_____ _____
(Signature of person completing form if not parent/guardian) (Contact number)

Parents are encouraged to attend their child's appointments. For questions about dental services or to reschedule your child's dental appointment call 24 hours prior to appointment time at the Integrated Arts Academy at 658-4869 or CHCB's Dental Center's main telephone number 652-1050. Late arrival to your appointment may require rescheduling.

Magaca Ilmaha: _____ Taariikhda Dhalashada Ilmaha: _____
(Dambe) (Hore) (Dhexe)

Foomka Taariikhda Caafimaadka/Ilkaha

Caafimaadka guud ee ilmahaaga, iyo sidoo kale daawooyinka uu ilmahaagu qaato waxay ku yeelan karaan raad muhiim ah daryeelka caafimaadka/ilkaha ilmahaaga.

Fadlan uga jawaab su'aalaha soo socda mid kasta sida dhammaystiran.

Waligaa ma laguu sheegay in ilmahaagu u baahan yahay antibayootik kahor shaqo ilkaha laga qabanayey? ☐ Haa ☐ Maya

Ilmahaagu wax dhibaato ah ma ku qabay shaqadii ilkaha ee hore? ☐ Haa ☐ Maya

Haddii ay haa tahay, fadlan sharrax: _____

_____

Taariikhda Caafimaad

Ilmahaagu ma qabaa wax kamid ah cudurrada ama dhibaatooyinka soo socda? Haddii ay haa tahay fadlan sax saar sanduuqa ku beegan:

HAA	MAYA		HAA	MAYA	
☐	☐	Xiiq	☐	☐	Gariir/Ibilaabsi
☐	☐	Kansar	☐	☐	Qaaxo
☐	☐	Cagaarshow	☐	☐	Dhiigbax Aan Caadi Ahayn
☐	☐	HIV/AIDS	☐	☐	Mushkiladda Saynas
☐	☐	Hemofiiliya	☐	☐	Dhiig-yaraan
☐	☐	Sonkorow	☐	☐	Xummadda Ruumaatik
☐	☐	Xasaasiyado	☐	☐	Laxaad La'aan/Naafo
☐	☐	Wadne Xanuunka lagu Dhasho	☐	☐	Haart Maamar Antibayootik ayaa loo baahan sida uu sheegay Dr. _____

Dhibaatooyin kale oo caafimaad oo caafimaad oo aan la xusin (Fadlan Sharrax):

_____

_____

Tax wixii daawooyin ilmahaagu qaadnayo (Fadlan ku dar daawooyinka dhakhtarku qoray iyo kuwa aanu qorin)

1. _____ 3. _____
2. _____ 4. _____

Miyuu ilmahaagu xasaasiyad ka qaadaa ama falcelin xun ka sameeyey wax kamid ah waxa soo socda?

HAA	MAYA		HAA	MAYA	
☐	☐	Suuxinta in jidhka ah (Novocain)	☐	☐	Beenasaliin ama antibayootik kale
☐	☐	Dheecaanka dhirta	☐	☐	Daawooyinka hurdada keena
☐	☐	Asbiriinka	☐	☐	Aayodhiin
☐	☐	Koodhiin ama naarkootig kale	☐	☐	Wax kale:

Fadlan hoos saxeex si aad u hubiso daryeel ilkeed/caafimaad oo sax ah in ilmahaagu helo. Inta aan ogahay, su'aalaha foomkan si sax ah ayaa looga jawaabay. Waan fahamsanahay in bixinta macluumaadka saxda ah ay khatar ku noqon karto caafimaadka ilmahayga. Waa masuuliyaddayda inaan ogaysiiyo xafiiska bixiyaha daryeelka caafimaadka wixii isbeddello ku yimaadda taariikhda caafimaadka ilmahayga. Sidoo kale waxaan oggolahay daawaynta sida raadhiyogaraafka, baadhitaaada caafimaaad ee caadiga ah (oo ay kujiraan buuxinaha iyo bixint) iyo in nijoricte ilmahayga la siiyo marka loo baahdo booqasho ilkeed oo kasta.

_____ _____

(Saxeexa waalidka/wakiilka) (Taariikhda) (Saeexa dhakhtarka ilkaha ee dib-u-eegaya taariikhda) (Taariikhda)

☐ **Tarjumaadda Hadalka ama Qoraalka ah ayaa la bixiyey waana la fahmay.**

_____

(Saxeexa qofka dhammaystiraya haddii aanu ahayn waalidka/wakiilka) (Lambarka Lagala Xidhiidhayo)

Waalidiinta waxa lagu dhiirigalinayaa inay yimaaddaan ballamaha carruurtooda. Wixii su'aalo kusaabsan adeegyada ilkaha ama si aad dib ballan ugu qabsato ballanta ilkaha ilmahaaga wac 24 saacadood kahor wakhtiga ballanta Integrated Arts Academy 658-4869 ama lambarka taleefanka Xarunta Ilkaha CHCB 652-1050. Haddii aad ka daahdo ballanta waxaad u baahan kartaa inaad dib u qabsato.

community health centers OF BURLINGTON

Child's Name:_____ **Child's Date of Birth:** _____
(Last) (First) (MI)

Medical/Dental History Form

Must be completed in advance of participation in the School-Based Dental Center

Consent to the Provision of Services

I authorize CHCB to see my child at the School-Based Dental Center:

- ☐ Whenever my child needs dental care
- ☐ Only when I have given specific written permission (except in the case of a medical, dental or behavioral health emergency)
- ☐ Only when I am present (except in the case of a medical, dental or behavioral health emergency)

Emergency Contact/Changes in Health Status or Custody

I further agree that I will promptly inform the School-Based Dental Center staff in writing of
1) any change in my child's physical or dental health and
2) any change in the custody or guardianship of my child which affects my ability to provide this Consent on behalf of my child.

Agreement Concerning Transportation to and from the School-Based Dental Center at the Integrated Arts Academy at The H.O. Wheeler School

Dental services for elementary, middle school and high school students are provided at the School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School. The State of Vermont has contracted with SSTA to provide transportation services for Medicaid eligible students to and from Burlington's schools and the School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School.

a) If my child needs transportation as indicated below, I consent to having CHCB schedule SSTA transportation to take my child to and from the H.O. Wheeler School for dental services, at no cost to me. CHCB may disclose information about my children's need for transportation and payment purposes.
b) I agree that SSTA may seek reimbursement from Medicaid for such transportation services.

If My Child is Seen at the End of the School Day, My Child:

- ☐ May walk home with their siblings named _____
- ☐ May walk home with a friend(s) named _____
- ☐ Should be transported to babysitter / child care provider named _____ located at _____ with this telephone number _____
- ☐ Should be transported home and dropped only if one of these adults is present:

_____

I (parent or guardian name), _____ have read the above material and understand its meaning. My signature below is an acknowledgment that I have reviewed this form, understand the information and consent to all of the actions described above. My signature also attests to the accuracy of the information provided on both sides of this form.

_____ _____
(Signature of parent/guardian) (Date)

☐ Interpretation or Translation offered and understood.

_____ _____
(Signature of person completing form if not parent/guardian) (Contact number)

Magaca Ilmaha: _____ Taariikhda Dhalashada Ilmaha:_____
(Dambe) (Hore) (Dhexe)

Foomka Taariikhda Caafimaadka/Ilkaha

Waa in la dhammaystiraa ka qayb qaadashada horaysa ee Xarunta Ilkaha ee Dugsiga

Oggolaanshaha Siinta Adeegyada

Waxa aan Oggolaaday in CHCB ay ilamahayga ku aragto Xarunta Ilkaha Ee Dugsiga:

□ Markasta oo ilmahaygu u baahdo daryeel ilkeed
□ Kaliya marka aan bixiyo oggolaanshiyo qoraal ah (marka laga reebo xaaladaha dagdaga ah ee caafimaad, ilkeed ama hab dhaqanka caafimaadka)
□ Kaliya marka aan joogo (marka laga reebo xaaladaha dagdaga ah ee caafimaad, ilkeed ama hab dhaqanka caafimaadka)

Xidhiidhka Dagdaga ah/Isbaddelada Xaalada Caafimaad ama Haynta

Waxaan aad u taageerayaa inaan si dagdag ah ugu wargalinayo shaqaalaha Xarunta Ilkaha ee Dugsiga aniga oo u qorayaI

1) isbaddel kasta caafimaadka jidhka iyo ilkaha iyo
2) isbaddel kasta oo ah haynta ama ilaalinta ilmahayga taasi oo saamaynaysa awoodayda aan ku bixinayo oggolaanshiyahan iyada oo la eegayo ilmahayga.

Heshiishka Khuseeya u qaadida iyo kasoo celinta Xarunta Ilkaha Dugsiga ee Integrated Arts Academy at The H.O. Wheeler School

Adeegyada ilkaha ardayda ee dugsiyada hoose, dhexe iyo sare waxa lagu bixiyaa Xarunta Ilkaha ee Dugsiga ee Integrated Arts Academy at H.O. Wheeler School. Gobolka Vermont waxa ay heshiis la galeen SSTA si ay u bixiso adeegyada qaadida ardayda xaqa u leh Medicaid si ay u geeyaan ugana soo celiyaan Dugsiyada Burlington iyo Xarunta ilkaha ee Dugsiga Integrated Arts Academy at H.O. Wheeler School.

a) Haddii ilmahaygu u baahdo qaadid sida halka hoose lagu muujiyay, waxa aan oggolaaday inaan qaato jadwalka CHCB ee qaadida SSTA si ay ilmahayga ugeeyaan ugana soo celiyaan H.O. Wheeler School ee adeegyada ilkaha, iyada oo aan wax kharasg ah igaga baxayn. CHCB waxa ay sheegi karta macluumaadka ee ku saabsan baahida ilmahayga ee qaadida iyo ujeedooyinka bixinta.
b) Waan taageersanahy in SSTA ay u raadiso abaalgud ka yimiday Medicaid adeegyadan qaadida oo kale.

Haddii ilmahayga la arko iyadoo Dugsiga la Fasaxay, Ilmahayga Waa in:If My Child is Seen at the End of the School Day, My Child:

□ La raaciyaa walaalahood laguna magacaabo
□ La raaciyaa saaxiibadood laguna magacaabo _____
□ Waa inuu qaadaa qofka ilmaha lagaga tagay/bixiyaha adeega ilmaha ee lagu magacaabo ___ _____
Kuna taala _____ telefoonkooduna uu yahay _____
□ wa in loo qaadaa guriga kaliyana la dajiyaa haddii dadkan waaweyn mid kamid ahi uu joogo:

_____

Waan(magaca waalidka ama wakiilka), _____akhriyay qoraalada sare waanan fahmay macnahooda. Saxeexayga hoose waa qiraal ah inaan dib u eegay foomkan, aanan fahmay macluumaadka aanan oggolaaday dhammaan ficilada lagu sharaxay halka sare. Saxeexaygu sidoo kale waxa uu caddaynayaa saxnaanshaha macluumadka lagu bixiyay labada dhinac ee foomkan.

_____ _____
(Saxeexa waalidka/wakiilka) (Taariikhda)

□ Tarjumaadda Hadalka ama Qoraalka ah ayaa la bixiyey waana la fahmay.

_____ _____
(Saxeexa qofka dhammaystiraya foomka haddii aanu waalid ahayn/wakiil) (Lambarka lagala xidhiidhayo)

community health centers OF BURLINGTON

Child's Name:_____ **Child's Date of Birth:** _____
(Last) (First) (MI)

Medical/Dental History Form

Consent to Treatment and Consent to Release of Health Information

for Treatment, Payment and Health Care Operations

I. Consent to Treatment

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to the Community Health Centers of Burlington, Inc. (CHCB). Treatment may include health screening, diagnosis, medical treatment, dental care; social services; and/or mental health and drug and alcohol screening, assessment, diagnosis and treatment. I further understand this Consent covers only dental services provided at the School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School and at the Community Health Centers of Burlington (CHCB). I understand CHCB will protect the privacy of my child's health and educational records to the extent required by federal and state law. I understand that a picture of my child will be taken for identification purposes only and kept within CHCB Records.

II. Consent to Release of Health Information, including Health/Treatment Records for Treatment, Payment and Health Care Operations

I consent to the use within CHCB and the disclosure to persons or organizations outside of CHCB of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, drug and alcohol, mental health and other treatment and health records and information (such health records and information are referred to in this Consent as my "Health Information") by CHCB for the following purposes:

A. Use of Health Information By or For CHCB for Treatment and for Health Care Operations:

- Providing treatment by CHCB staff;
- Conducting health care operations of CHCB including, for example, financial or quality assurance audits and training.

B. Disclosure of Health Information to Persons Outside CHCB for Treatment Purposes and for Payment

- Providing all necessary Health Information as determined by CHCB, including information about treatment for drug or alcohol abuse, to any of the following health providers if I am referred there for treatment: University of Vermont Medical Center, Allergy & Asthma Associates, Champlain Valley Foot & Ankle, Associates in Orthopedic Surgery, Appletree Bay Physical Therapy, Four Seasons Dermatology, Evolution Physical Therapy & Yoga, Hand Surgery Associates, Green Mountain Physical Therapy, or the Rehab Gym.
- Providing Health Information to other health providers or agencies not listed above who may be involved in my care (except for information concerning treatment for drug or alcohol abuse for which a separate consent is required);
- Obtaining payment for health care bills, including sending such Health Information as is needed to secure payment for CHCB services to the insurance company, worker's compensation company or agency that pays for my health services, as identified in my CHCB Registration form or other updated insurance information on file with CHCB.
- School-Based Dental Program may share treatment and health information with Burlington School District social workers, school health personnel, counselors, principal, SSTA and Community Health Centers of Burlington (CHCB).

III. Other Matters

I understand that I have the right to revoke this Consent at any time, but revoking this Consent will not affect any actions which were taken by CHCB in reliance on this Consent before I revoked it. If not previously revoked, this consent will terminate on the following date, event, or condition: _____. If none is indicated, this consent will terminate three years after the last date of services to me.

I understand that I may request restrictions on use or disclosure of my Health Information for the purposes described in this Consent and that CHCB may or may not agree to the requested restrictions. I also understand that except for those restrictions on use or disclosure of Health Information to which it agrees, CHCB will not be able to provide services to me (or the named patient) without this signed Consent.

_____ _____

(Signature of parent/guardian) (Date) (Signature of dentist reviewing history) (Date)

☐ Interpretation or Translation offered and understood.

_____ _____

(Signature of person completing form if not parent/guardian) (Contact number)

Magaca Ilmaha: _____ Taariikhda Dhalashada Ilmaha:_____
(Dambe) (Hore) (Dhexe)

Foomka Taariikhda Caafimaadka/Ilkaha

Oggolaanshaha Daawaynta iyo Oggolaanshaha Fasaxa Macluumaadka Caafimaadka ee Daawaynta, Lacag-bixinta iyo Hawlgallada Daryeelka Caafimaadka

I. OggolaanshahaDaawaynta

Waxaan halkan ku caddaynayaa inaan u oggolahay daawayntanaftayda, ama bukaanka la xusay (kaasi oo aan u ahay waalid ama masuul sharci ah oo xaq u leh oggolaanshahadaawayntabukaankala xusay) Community Health Centers of Burlington, Inc. (CHCB). Daawaynta waxa dhici karta inay kujiraan baadhis caafimaad, daawayn caafimaad, daryeel ilkeed; adeegyada bulshada; iyo/ama caafimaadka maskaxda iyo baadhista daroogada iyo khamrada, qiimayn, baadhisiyo daawayn.
Waxaan kaloon fahamsanay in oggolaanshiyahani uu kaliya daboolayo adeegyada ilkaha ee uu bixiyo Xarunta Ilkaha ee Dugsigu ee Integrated Arts Academy at H.O. Wheeler School ee Xarumaha Bulshada ee Burlington (CHCB). Waan Fahamsanahay in CHCB ay ilaalin doonto sirta caafimaadka iyo diiwaanka waxbarashada ee ilmahayga ilaa heerka ay oggoshahay xeerka dawlada iyo gobolkuba. Waan fahamsanahay in sawir ilmahayga ah la qaadi doono ujeedo caddayn darteed laguna ilaalin doono diiwaanada CHCB.

II. Oggolaanshaha u Fasixidda Macluumaadka Caafimaad, oo ay kujiraan Diiwaanada Caafimaadka/Daawaynta ee Daawaynta, Hawlgallada Lacag-bixinta iyo Daryeelka Caafimaadka

Waxaan u oggolahay isticmaalka gudaha CHCB iyo u tusidda dadka iyo ururrada dibadda ka ah CHCB (ama bukaanka la xusay ee aan waalidka ama masuulka sharciga ah u ahay) diiwaanadayga iyo macluumaadkayga caafimaad, ilkeed, daroogo iyo khamro, caafimaadka maskaxda iyo daawaynta kale (diiwaanadan iyo macluumaadkan caafimaad waxa loo tixraacaa Oggolaanshahan "Macluumaadkayga Caafimaad") ee CHCB ujeedooyinka soo socda:

C. Isticmaalka Macluumaadka Caafimaad ee ay Isticmaalayso ama u Isticmaalayso CHCB Daawaynta iyo Hawlgallada Daryeelka Caafimaad:

- Bixinta daawayn ee hawlwadeenada CHCB;
- Samayn hawlgallada daryeelka caafimaad ee CHCB oo ay kujiraan, tusaale ahaan, baadhitaanada iyo tabobarrada dhaqaale ama ilaalinta tayada.

D. U tusidda Macluumaadka Caafimaad Dadka Dibadda ka ah CHCB Ujeedooyinka Daawayn iyo Lacag-bixin

- Siinta Macluumaadka Caafimaad ee daruuriga ah oo dhan marka ay go'aamisay CHCB, oo ay kujiraan macluumaadka kusaabsan daawaynta isticmaalka daroogada ama khamrada, cid kasta oo kamid ah bixiyayaasha caafimaad ee soo socda haddii halkaas la iigu gudbiyo daawayn ahaan: University of Vermont Medical Center, Allergy & Asthma Associates, Champlain Valley Foot & Ankle, Associates in Orthopedic Surgery, Appletree Bay Physical Therapy, Four Seasons Dermatology, Evolution Physical Therapy & Yoga, Hand Surgery Associates, Green Mountain Physical Therapy, ama Rehab Gym.
- Siinta Macluumaadka Caafimaad bixiyayaasha caafimaadka ama hay'adaha kale ee aan sare ku qornayn kuwaasi oo ku lug yeelan kara daryeelkaaga (laga reebo macluumaadka khuseeya daawaynta isticmaalka daroogada ama khamrada kuwaasi oo iyaga oggolaansho gaar ah loo baahan yahay);
- Helista lacagta daryeelka caafimaad, oo ay kujiraan u dirista Macluumaadkan Caafimaad marka looga baahan yahay in la helo lacag adeegyada CHCB shirkadda caymiska, shirkadda magdhawga shaqaalaha ama hay'ad bixisa lacagta adeegyada caafimaadkayga, sida ku foomkayga Diiwaangalinta CHCB ama macluumaad caymis oo la cusboonaysiiyey oo kale oo ka fayl garaysan CHCB.
- Barnaamijka Xarunta Ilkaha ee Dugsigu waxa uu la wadaagi doonaa daaweynta iyo macluumaadka caafimaad adeegayaasha bulshada ee Dugsi Degmeedka Burlington, shaqaalaha caafimaadka ee dugsiga, la taliyayaasha, maamulka, Xarumaha Caafimaadka SSTA iyo Bulshada ee Burlington (CHCB).

III. Arrimaha Kale

Waan fahamsanahay inaan xaq u leeyahay inaan ka laabto Oggolaanshahan marka aan doono, laakiin ka laabashada Oggolaanshahan ayna saamayn doono wixii tallaabo ay qaaday CHCB iyadoo isku-hallaynaysa Oggolaanshahan kahor intaanad ka laaban. Haddii aan hore looga laaban, oggolaanshahan wuxuu dhammaan doonaa taariikhda, dhacdada, ama xaaladda soo socota: _____.
Haddii aan waxba la sheegin, oggolaanshahan wuxuu dhammaan saddex sano kadib taariikhda u dambaysa ee aan adeegga helo.
Waan fahamsanahay inaan codsan karo xannibaado la saaro isticmaalka ama tusidda Macluumaadkayga Caafimaad marka la eego ujeedooyinka ku qeexan Oggolaanshahan iyo in CHCB ay dhici karto inay igu raacdo ama igu diido xannibaadaha aan codsado. Sidoo kale waan fahamsanahay in laga reebo xannibaadahaas isticmaalka ama tusidda Macluumaadka Caafimaad ee ay oggolaatay (CHCB), CHCB awood ayna awood u yeelan doonin inay adeegyo siiso aniga (ama bukaanka la xusay) la'aanta Oggolaanshahan saxeexan.

(Saxeexa waalidka/wakiilka) (Taariikhda)

(Saxeexa dhakharka ilkaha ee dib u eegaya taariikhda) (Taariikhda)

□ Tarjumaadda Hadalka ama Qoraalka ah ayaa la bixiyey waana la fahmay.

(Saxeexa qofka dhammaystiraya foomka haddii aanu waalidka ahayn/wakiilka)

(Lambarka lagala Xidhiidhayo)

community health centers OF BURLINGTON

Child's Name:_____ **Child's Date of Birth:** _____
(Last) (First) (MI)

Medical/Dental History Form

I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of my care at CHCB.

I understand that, to the best of my knowledge, the demographic information I have provided is true and correct.

I have read the Consent to Treatment & Consent to Release of Health Information and I understand and consent to its content.

I hereby acknowledge that I have been offered a copy of CHCB's Payment Expectations document and understand and agree to adhere to these expectations.

Assignment of Benefits
I hereby assign to CHCB any and all payments to which I am entitled under Medicaid or any health insurance policy for health care, behavioral health, or dental health services rendered to me by CHCB as long as the charges for services by CHCB do not exceed CHCB's regular charges. I further authorize CHCB to bill and receive payment directly from Medicaid or my insurance carrier(s) for those services that CHCB delivered and for which I may be entitled to insurance coverage. I also authorize CHCB to give Medicaid or my health insurance carrier(s) any information necessary for billing purposes for services provided for such periods of time as I have received or am receiving primary health care, behavioral health, or dental health services.

Patients at the Community Health Centers of Burlington consent to disclosure of information for purposes of treatment, payment, and health care operations. Patient may consent to receipt or disclosures of health care information for other purposes as well.

Patients requesting information in regards to drug and alcohol counseling/treatment need to complete a separate authorization. No drug and alcohol information will be given without this permission.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand how CHCB may and may not use my protected health information in accordance with privacy law.

I understand that the Community Health Centers of Burlington, Inc may use any e-mail address or mobile phone number provided to contact me for appointment reminders or other announcements.
E-mail addresses and mobile phone numbers will not be sold to a third party or used for marketing purposes.

Name of Patient:_____ Date of Birth _____

Patient Signature:_____ Date: _____

Parent/Guardian: _____

Parent/Guardian Signature:_____ Date:_____

☐ Interpretation or Translation offered and understood.

_____ _____
(Signature of person completing form if not parent/guardian) (Contact number)

Magaca Ilmaha: _____ Taariikhda Dhalashada Ilmaha:_____
(Dambe) (Hore) (Dhexe)

Foomka Taariikhda Caafimaadka/Ilkaha

Waan fahamsanahay oo aan qirsanahay inaan dhaqaale ahaan ka masuul ahayn wixii baaqiyo aan la bixin loo galay daryeelkayga dartii iyadoo la joogo CHCB.

Waan fahamsanahay, inta awooddayda ah, macluumaadka dimugaraafi ee aan bixiyey inay dhab iyo sax yihiin.

Waan akhriyey Oggolaanshaha Daawaynta oo aan Oggolaaday Fasixidda Macluumaadka Caafimaad oo aan fahamsanahay oo aan oggolaaday waxa uu ka kooban yahay.

Waxaan qirayaa in la i siiyey nuqul dokumentiga Filashooyinka Lacag-bixinta CHCB oo aan fahamsanahay oggolahayna inaan u hoggaansanaado filashooyinkan.

U Tiirinta Dheefaha

Waxaan halkan ugu tiirinayaa CHCB wixii iyo dhammaan lacag-bixinaha aan xaqa ugu yeeshay Medicaid ama caymis caafimaad oo kale ee daryeelka caafimaadka, caafimaadka habdhaqan, ama adeegyada caafimaadka ilkeed ee ay ii qabatay CHCB ilaa iyo inta khidmadaha adeegyadu CHCB qabatay ayna ka badnaan khidmadaha caadiga ah ee CHCB. Sidoo kale waxaan oggolaanayaa CHCB inay ku dallacato kana hesho lacagaha si toos ah Medicaid ama shirkadda caymiskayga adeegyada CHCB ay bixisay kuwaasi oona ay dhici karto inaan xaq u yeeshay in caymiska laga bixiyo. Sidoo kale waxaan u oggolaanayaa CHCB inay siiso Medicaid ama shirkadda caymiskayga wixii macluumaad u daruuri ah qaansheegta adeegyada la i siiyey wakhtiyadan marka aan helay ama aan helayo daryeelka caafimaadka koowaad, caafimaadka habdhaqan, ama adeegyada caafimaadka ilkeed.

Bukaanada Xarumaha Caafimaadka Bulshada ee Burlington waxay oggol yihiin in loo tuso macluumaadka ujeedooyinka daawaynta, lacag-bixinta, iyo hawlgallada daryeelka caafimaadka. Bukaanadu waxa dhici karta inay u oggolaadaan helitaanka ama tusidda macluumaadka daryeelka caafimaadka ujeedooyin kale sidoo kale.

Bukaanada codsanaya macluumaad la xidhiidha la-talinta/daawaynta daroogada iyo khamrada waxay u baahan yihiin inay dhammaystiraan oggolaansho gaar ah. Macluumaad daroogo iyo khamro la bixin maayo la'aanta ruqsaddan.

Waxaan qirayaa in la i siiyey nuqul Ogaysiiska Ku-camalfalka Asturnaanta aanan fahamsanahay sida CHCB ay dhici karto inay u isticmaasho ama ayna u isticmaalin macluumaadka caafimaadkayga ee ilaashan iyadoo la raacayo sharciga asturnaanta.

Waan fahamsanahay in Xarumaha Caafimaadka Bulshada ee Burlington, Inc. ay dhici karto inay u isticmaalaan wixii iimeyl ama lambar taleefanka gacanta ah ee la siiyey inay igala soo xidhiidhaan xasuusiyayaasha ballamaha ama ogaysiisyada kale. Iimeylada iyo lambarrada taleefannada gacanta laga gadi maayo cid saddexaad ama loo isticmaali maayo ujeedooyin suuqgayneed.

Magaca Bukaanka: _____ Taariikhda Dhalashada: _____

Saxeexa Bukaanka: _____ Taariikhda: _____

Waalidka/Masuulka: _____

Saxeexa Waalidka/Masuulka: _____ Taariikhda: _____

☐ Tarjumaadda Hadalka ama Qoraalka ah ayaa la bixiyey waana la fahmay.

_____ _____

(Saxeexa qofka dhammaystiraya foomka haddii aanu waalidka /wakiilka ahayn) (Lambarka Lagala Xidhiidhayo)

community health centers OF BURLINGTON

Student's Name:_____ Student's Date of Birth: _____
(Last) (First) (MI)

Important Information About Silver Diamine Fluoride

Silver Diamine Fluoride (SDF): Is an antibiotic liquid. We apply it to teeth to help STOP tooth decay. SDF causes the decay to turn black; ONLY THE DECAYED area will turn black. Healthy tooth structure will not be affected. In some cases the tooth may not require any additional dental treatment.

Benefits of using SDF:

- Patient does not need to get a shot, no numbing medicine needed! Application of SDF is painless as it is brushed onto the tooth surface just like regular fluoride!
- Painless and easy to apply!

Disadvantages of SDF:

- Stains location of decay a "black/brown" color.
- Most effective with multiple applications.
- The teeth treated may still need routine dental treatment in the future (fillings, extraction) depending on the extent of decay.

I am the Parent/Guardian of: **Name**_____ **DOB**_____. I have read the above information and understand its meaning.

My signature below is an acknowledgement that I have reviewed this form, understand the information, and consent to all of the actions listed above. My signature also attests to the accuracy of the information provided on this form.

Signature of Parent/Guardian_____Date_____

Taariikhda Dhalashada Ardayga: _____

(Sadexaad) (Kowaad) (Dhexe)

Macluumaad Muhiim ah oo Ku Saabsan Silver Diamine Fluoride

Silver Diamine Fluoride (SDF): Waxaa weee dareere antibootig ah. Waxaanu marinaa ilkaha si aanu u JOOJINO inay dalooshamaan. SDF waxay keentaa inay qaybt talooshantaa mdaw noqoto; KALIYAHA aaga DALOOSHAHA ayaa noqda madaw. Ilmaha caafimaadka qaba ma saamayn doono. Mararka qaar iligu uma baahdo daawayn ilkaha oo dheeraad ah.

Faa'idada istimcaalka SDF:

- Bukaanku uma baahdo irbad, iyo dawada suuxisada! Marinta SDF malaha xanuun maadaama oo burush lagu mariyo dusha iliga sida fluoride caadiga ah oo kale!
- Bilaa xanuun oo si fudud oo marin karo!

Faa'ido darasada SDF:

- Waxay ka dhigtaa meesha uu suusku galay "madaw/buni".
- Waxay wax tartaa marka dhawr jeer la mariyo.
- Ilkaha lagu daweeyaa waxay u baahan karaan daawayn joogto ah mustaqbalka (buuxin, saaritaan) taas oo ku xidhan heerka suusku yahay.

Waxaan ahayn Waalidka/Koriyaha: **Magaca**_____ **Taariikhda Dhalashada** _____
Waxa aan waxaan akhriyay macluumaadka sare oo waan fahmay waxa uu ka dhigan yahay.

Saxeexayga hoose waa qiraal in aan akhriyay foomkan, fahmay macluumaadka, oo waxa aan ogolaaday dhamaan talaabooyinka ku qoran sare. Saxeexaygu waxa uu sidoo kale muujinayaa saxnaanta macluumaadka ku qoran foomkan.

Saxeexa Waalidka/Koriyaha _____Taariikhda_____