Community Health Centers

FOMU YA USAJIWA WA MGONJWA

Imethibitishwa na:

TAREHE REK/IMEINGIZWA:___/___/___

VIFUPISHO VYA MFANYAKAZI:_____

AINA YA MIADI/MATUMIZI YA WAFANYAKAZI PEKEE ☐ **MATIBABU** ☐ **MENO**

☐ Riverside ☐ Safe Harbor ☐ Pearl Street ☐ South End ☐ Champlain Islands ☐ Good Health ☐ Winooski ☐ Essex

TAARIFA ZA MGONJWA *TAFADHALI KAMILISHA (Jaza) fomu yote kwa Kalamu Nyeusi au Buluu Pekee*

JINA LA MWISHO	JINA LA KWANZA	VIFUPISHO VYA KATI	JINA LA UTANI/JINA LILILOCHAGULIWA
ANWANI YA MTAA	JIJI	JIMBO	ZIP

NAMBA YA HIFADHI YA JAMII #	TAREHE YA KUZALIWA	SIMU YA NYUMBANI	SIMU YA MCHANA	SIMU YA MKONONI

ANWANI YA BARUA PEPE

NJIA UIPENDAYO YA MAWASILIANO ☐ SIMU ☐ BARUA PEPE ☐ UJUMBE WA MAANDISHI

HALI YA NDOA
☐ Sijaoa/Sijaolewa ☐ Tumetengana
☐ Nimeoa/Nimeolewa ☐ Mjane
☐ Tumetalikiana ☐ Umoja wa Raia

JAMII
☐ Mmarekani-Mwafrika ☐ Mmarekani Asilia
☐ Mmarekani-Muasia ☐ Mkazi wa Visiwa vya Pasifiki
☐ Mzungu/Mweupe ☐ Jamii mchanganyiko

Lugha ya Kwanza kama Sio Kiingereza:_____

Je, Unahitaji Huduma za Wakalimani? ☐ NDIYO ☐ HAPANA

Kabila/Asili: ☐ Kihispania ☐ Sio Kihispania

Daktari wa Huduma za Msingi

MFANYAKAZI WA KILIMO ☐ Mhamiaji ☐ Msimu

Je, Wewe ni Mstafu wa Jeshi La Marekani? ☐ Ndiyo ☐ Hapana

TAARIFA ZA FEDHA ZA FAMILIA

Tukiwa kama Kituo cha Afya ambacho kinapokea ufadhili wa Serikali Kuu, tunatakiwa kukusanya taarifa hii. Majibu yote ni siri.

Ukubwa wa Familia/Kaya:_____

Mapato ya Kaya: $_____

☐ Kila Wiki ☐ Kila Mwaka
☐ Kila Baada ya Wiki Mbili
☐ Kila Mwezi

JINSIA YA KISHERIA
☐ MWANAUME
☐ MWANAMKE

JINSIA YA SASA
☐ MWANAUME
☐ MWANAMKE

VIWAKILISHI (Hiari)

_____

UTAMBULISHO WA KIJISHIA
☐ MWANAUME
☐ MWANAMKE
☐ NIMEBADILI JINSIA MWANAUME (Mwanamke-kuwa-Mwanaume/FTM)
☐ NIMEBADILI JINSIA MWANAMKE (Mwanamke-kuwa-Mwanamke/MTF)
☐ MSENGE/MSAGAJI
☐ NYINGINE
☐ NACHAGUA KUTOJIBU

MUELEKEO WA KINGONO
☐ ULIOZOELEKA au ANAYEVUTIWA NA JINSIA NYINGINE
☐ MSAGAJI, MSENGE au ANAYEVUTIWA NA JINSIA MOJA
☐ ANAYEVUTIWA NA JINSIA MBILI
☐ KITU KINGINE
☐ SIJUI
☐ NACHAGUA KUTOJIBU

HALI YA MAKAZI Je, Wewe Huna Makazi? ☐ NDIYO ☐ HAPANA

Kama huna makazi: ☐ Mnabebana (unaishi na watu wengine) ☐ Makazi ☐ Mtaani ☐ Mpito ☐ Haijulikani

DUKA LA DAWA UNALOPENDELEA

JINA LA DUKA LA DAWA	ENEO LA DUKA LA DAWA

MAWASILIANO YA DHARURA

JINA	UHUSIANO	NAMBA YA SIMU

TAARIFA YA UPANDE UNAOHUSIKA (Mgonjwa yeyote mwenye umri chini ya miaka 18 lazima awe na upande unaohusika)

☐ Mgonjwa (chini ya miaka 18) ☐ Mzazi Mlezi ☐ Mlezi (uthibitisho wa hali ya kisheria inahitajika kwa ajili ya matibabu)

JINA LA MWISHO	JINA LA KWANZA	MI
ANWANI YA MTAA	JIJI	JIMBO	ZIP

TAREHE YA KUZALIWA	SIMU YA NYUMBANI

TAARIFA ZA BIMA YA MENO

☐ **Kwa sasa nina bima ya MENO (tazama hapa chini)**
☐ **Kwa sasa SINA bima ya MENO**
☐ **Ningependa kutuma maombi ya KIWANGO CHA PUNGUZO LA ADA**

Jina la Bima ya Meno:_____

Sera/Namba ya Kitambulisho_____

☐ **Kwa sasa nina bima ya MENO ya pili (tazama hapa chini)**

Jina la Bima ya Meno:_____

Sera/Namba ya Kitambulisho_____

TAARIFA YA BIMA YA MATIBABU

☐ **Kwa sasa nina bima ya MATIBABU (tazama hapa chini)**
☐ **Kwa sasa SINA bima ya MATIBABU**
☐ **Ningependa kutuma maombi ya KIWANGO CHA PUNGUZO LA ADA**

Jina la Bima ya Matibabu:_____

Sera/Namba ya Kitambulisho_____

☐ **Kwa sasa nina bima ya MATIBABU ya pili (tazama hapa chini)**

Jina la Bima ya Matibabu:_____

Sera/Namba ya Kitambulisho_____

Community Health Centers

PATIENT REGISTRATION FORM

Verified By:
DATE REC/ENTERED: ___/___/___
STAFF INITIALS: _____

APPOINTMENT TYPE/STAFF USE ONLY ☐ **MEDICAL** ☐ **DENTAL**

☐ Riverside ☐ Safe Harbor ☐ Pearl Street ☐ South End ☐ Champlain Islands ☐ Good Health ☐ Winooski ☐ Essex

PATIENT INFORMATION *PLEASE COMPLETE (Fill out) entire form in Black or Blue Pen Only*

LAST NAME | FIRST NAME | MIDDLE INITIAL | NICKNAME/CHOSEN NAME

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE | DAY PHONE | CELL PHONE

EMAIL ADDRESS

PREFERRED CONTACT METHOD
☐ PHONE ☐ EMAIL ☐ TEXT MESSAGE

MARITAL STATUS
☐ Single ☐ Separated
☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union

RACE
☐ African-American ☐ Native American
☐ Asian-American ☐ Pacific Islander
☐ Caucasian/White ☐ Multi-racial

Primary Language if Not English: _____
Do You Need Interpreter Services? ☐ YES ☐ NO
Ethnicity/Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic

Primary Care Physician

AGRICULTURAL WORKER
☐ Migrant ☐ Seasonal

Are You a U.S. Veteran?
☐ Yes ☐ No

LEGAL SEX
☐ MALE
☐ FEMALE

CURRENT GENDER
☐ MALE
☐ FEMALE

PRONOUNS (Optional):
_____

GENDER IDENTITY
☐ MALE
☐ FEMALE
☐ TRANSGENDER MALE (Female-to-Male/FTM)
☐ TRANSGENDER FEMALE (Male-to-Female/MTF)
☐ GENDERQUEER
☐ OTHER
☐ CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION
☐ STRAIGHT or HETEROSEXUAL
☐ LESBIAN, GAY or HOMOSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DON'T KNOW
☐ CHOOSE NOT TO DISCLOSE

FAMILY FINANCIAL INFORMATION
As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

Family/Household Size: _____
Household Income: $ _____
☐ Weekly ☐ Annually
☐ Biweekly
☐ Monthly

HOUSING STATUS Are You Homeless? ☐ YES ☐ NO
If homeless, are you: ☐ Doubling Up (living with others) ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown

PREFERRED PHARMACY

PHARMACY NAME | PHARMACY LOCATION

EMERGENCY CONTACT

NAME | RELATIONSHIP | PHONE NUMBER

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)

☐ **Patient** (18 years or older) ☐ **Custodial Parent** ☐ **Guardian** (proof of legal status required for treatment)

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | HOME PHONE

DENTAL INSURANCE INFORMATION

☐ **I currently have DENTAL insurance (see below)**
☐ **I currently DO NOT have DENTAL insurance**
☐ **I would like to apply for the SLIDING-FEE SCALE**

Dental Insurance Name: _____
Policy/ID Number: _____

☐ **I currently have secondary DENTAL insurance (see below)**

Dental Insurance Name: _____
Policy/ID Number: _____

MEDICAL INSURANCE INFORMATION

☐ **I currently have MEDICAL insurance (see below)**
☐ **I currently DO NOT have MEDICAL insurance**
☐ **I would like to apply for the SLIDING-FEE SCALE**

Medical Insurance Name: _____
Policy/ID Number: _____

☐ **I currently have secondary MEDICAL insurance (see below)**

Medical Insurance Name: _____
Policy/ID Number: _____

Community Health Centers

• RIVERSIDE • SAFE HARBOR • PEARL STREET • SCHOOL-BASED DENTAL CENTER •
• CHAMPLAIN ISLANDS • SOUTH END • GOOD HEALTH • WINOOSKI • ESSEX •

Idhini ya Matibabu na Idhini ya Kutoa Taarifa za Afya

I. Idhini ya Matibabu

Ninatoa idhini yangu ya matibabu kwa ajili yangu mwenyewe, au kwa ajili ya mgonjwa aliyetajwa (ambaye mimi ni mzazi au mlezi halali ambaye ana haki ya kukubali matibabu ya mgonjwa aliyetajwa) kwa Vituo vya Afya vya Jamii (CHC). Matibabu yanaweza kujumuisha uchunguzi wa afya, utambuzi, matibabu, huduma za meno, huduma za kijamii, afya ya akili au uchunguzi wa matumivi ya madawa ya kulevya na pombe, tathmini, utambuzi na matibabu, na huduma za afya ya akili.

II. Idhini ya kutoa taarifa za afya

Ninakubali CHC kutumia kumbukumbu zangu (au za mgonjwa aliyetajwa ambaye mimi ni mzazi au mlezi wa kisheria) za matibabu, meno, matumizi ya madawa ya kulevya na pombe, afya ya akili, ugonjwa wa akili na matibabu mengine ("taarifa za afya") ndani ya CHC na kuzitoa kwa watu au mashirika nje ya CHC kwa madhumuni yafuatayo:

A. Matumizi ya taarifa za afya ya CHC kwa ajili ya matibabu, malipo, na shughuli za huduma za afya:

- Kutoa matibabu kunakotekelezwa na wafanyakazi wa CHC.
- Uendeshaji wa shughuli za huduma za afya, ikiwemo ukaguzi na/au mafunzo ya fedha au udhibi wa ubora.
- Iandikie bili kampuni yako ya bima moja kwa moja
- Malipo ya huduma zinazotolewa na CHC. CHC imeidhinishwa kupata malipo ya huduma za afya na inaweza kuwasilisha taarifa za afya kwenye kampuni za bima, bima ya fidia kwa wafanyakazi au mashirika mengine ambayo hulipia huduma za afya, au taarifa nyingine mpya za bima kwenye faili la CHC.

B. Utoaji wa taarifa za afya kwa watu au mashirika nje ya CHC kwa ajili ya matibabu:

- CHC imeidhinishwa kutoa taarifa zote za afya kwa watoa huduma wengine wa afya au mashirika ambayo yanashiriki kukupatia huduma. Hii ni pamoja na taarifa za afya za zamani kutoka nje ya mashirika. (Utoaji wa mwisho wa taarifa lazima uwasilishwe kwa familia zote, marafiki, au watu wengine ambao ungetaka wapate taarifa zako za matibabu.)

Consent for Treatment and Consent to Release Health Information

I. Consent for 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 (CHC). Treatment may include health screening, diagnosis, medical treatment, dental care, social services, mental health or drug and alcohol screening, assessment, diagnosis and treatment, and psychiatry services.

II. Consent to release health information:

I consent to the use within CHC and the disclosure to persons or organizations outside of CHC of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, drug and alcohol, mental health, psychiatry and other treatment and health records ("health information") by CHC for the following purposes:

A. Use of health information by or for CHC for treatment, payment, and health care operations:

- Providing treatment by CHC staff.
- Conducting health care operations, including financial or quality assurance audits and/ or training.
- Bill your insurance company directly
- Payment for services provided by CHC. CHC is authorized to obtain payment for health care services and can provide health records to insurance companies, workers compensation insurers or other agencies that pay for health services, or other updated insurance information on file with CHC.

B. Disclosure of health information to persons or organizations outside of CHC for treatment purposes:

- CHC is authorized to provide all health information to other health providers or agencies who participate in your care. This includes past medical records from outside organizations. (An Individual release of information must be submitted for all family, friends, or other persons that you wish to access your Medical Record information.)

III. Assignment of Benefits

I authorize CHC to bill and receive payment directly from Medicaid /Medicare or any other insurance carrier for services provided to me.

I hereby assign to CHC all payments from Medicaid, Medicare, or any health insurance policy for health care, rendered to me by CHC.

I understand I am responsible for any unpaid balances incurred because of my care at CHC.

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

A copy of the CHC payment expectations is available per your request.

Community Health Centers

III. Ugawaji wa faida

Ninairuhusu CHC kiandikia bili na kupokea malipo moja kwa moja kutoka Medicaid/Medicare au watoa huduma wengine wa bima kwa huduma nilizopewa.

Kwa hiyo ninaipatia CHC malipo yote kutoka Medicaid, Medicare, au sera yoyote ya bima ya afya kwa huduma za afya, nilizopewa na CHC.

Ninaelewa kwamba nina wajibu wa kulipa kiasi chochote ambacho hakijaliwa kinachotokana na huduma nilizopatiwa na CHC.

Ninaelewa kwamba, kwa ufahamu wangu wote, taarifa za kidemografia nilizotoa ni za kweli na sahihi**.**

Nakala ya matarajio ya malipo ya CHC inapatikana utakapoiomba.

IV. Ukiukaji na mipaka ya idhini hii:

A. Ninaelewa kwamba nina haki ya kufuta idhini hii wakati wowote kwa maandishi, kufuta idhini hii hakutaathiri hatua zozote zilizochukuliwa na CHC kwa kutegemea idhini hii kabla ya kufutwa. Ikiwa haijafutwa hapo awali, idhini hii itaisha tarehe ifuatayo: _____. Ikiwa hakuna kilichobainishwa, idhini hii itaisha miaka mitatu baada ya tarehe ya mwisho kupatiwa huduma.

B. Ninaelewa kwamba ninaweza kuomba kuweka mipaka ya matumizi au utoaji wa taarifa zangu za afya kwa madhumuni yaliyoelezewa katika idhini hii na kwamba CHC inaweza kukubali au kukataa ombi hilo. Pia ninaelewa kwamba isipokuwa kwa mipaka hiyo ya matumizi au utoaji wa taarifa za afya ambayo CHC inaikubali, CHC haitaweza kukupa huduma (au mgonjwa aliyetajwa) bila idhini hii iliyosainiwa.

C. Nimeisoma Idhini hii ya Matibabu na Idhini ya Kutoa Taarifa za Afya, na ninaelewa na kujua maudhui ya idhini hii.

Ninathibitisha kuwa huduma za matumizi ya lugha nilipatiwa kabla ya kusaini fomu hii ya Idhini ya Matibabu na Idhini ya Kutoa Taarifa za Afya.

INATAKIWA

Jina la Mgonjwa:_____ Tarehe ya Kuzaliwa_____
Sahihi ya Mgonjwa:_____ Tarehe:_____
Mzazi/Mlezi:_____
Sahihi ya Mzazi/Mlezi:_____ Tarehe:_____

IV. Termination and restrictions of this consent:

A. I understand that I have the right to cancel this consent at any time in writing, cancelling this consent will not affect any actions taken by CHC in reliance of this consent before it was cancelled. If not previously cancelled, this consent will end on the following date: _____. If none is indicated, this consent will end three years after the last date of services to me.

B. I understand that I may request restrictions on the use or disclosure of my health information for the purposes described in this consent and that CHC may or may not agree to the request. I also understand that except for those restrictions on use or disclosure of health information to which it agrees, CHC will not be able to provide services to you (or the named patient) without this signed consent.

C. I have read this Consent for Treatment & Consent to Release of Health Information and I understand and knowingly consent to its content.

I confirm that language access services were provided to me before I signed this Consent for Treatment & Consent to Release of Health Information form. ☐

REQUIRED

Name of Patient:_____Date of Birth_____
Patient Signature:_____Date:_____
Parent/Guardian:_____
Parent/Guardian Signature:_____Date:_____

Community Health Centers
SCHOOL-BASED DENTAL CENTER

Vifupisho vya Mganga wa Meno:

Fomu ya Historia ya Matibabu/Meno

Jina la Mtoto: _____ Tarehe ya kuzaliwa: _____

Shule Anayosoma Mtoto: _____ Tarehe ya leo: _____

Historia ya Matibabu

Tafadhali chagua tatizo lolote la afya ambalo mtoto wako analo:

☐Pumu
☐Saratani
☐Homa ya Manjano
☐VVU/UKIMWI
☐ Hemophilia
☐Kisukari
☐Mizio
☐ Tatizo la Moyo la Kuzaliwa
☐Mshtuko/Kifafa
☐Kifua Kikuu
☐Kutokwa Damu Kusiko kwa Kawaida
☐Tatizo la Uwazi katika Mfupa
☐Upungufu wa damu
☐Homa Baridi Yabisi
☐Ulemavu wa Viungo/Ulemavu
☐Kuugua kwa Moyo
☐ ADHD
☐Ugonjwa wa Akili wa Watoto wa Spektra
☐Nyingine (tafadhali bainisha): _____

Taarifa Zingine za Afya

Tafadhali chagua tatizo lolote la afya ambalo mtoto wako analo:

☐Mtoto wangu anavuta bidhaa za tumbaku
- Kama ndiyo, kiasi gani? _____
- Je, yuko radhi kuacha? _____

☐ Mtoto wangu anatumia madawa ya kuburudisha
☐Mtoto wangu anakunywa pombe
☐ Mtoto wangu ni mjamzito au inawezekana ni mjamzito
☐ Mtoto wangu ana vidonda mdomoni mwake jambo linalofanya iwe tatizo
☐ Mtoto wangu amekabiliwa na matatizo katika matibabu yake ya awali ya meno
☐ Mtoto wangu alikuwa ameambiwa kwamba anahitaji viua vijasumu kabla ya matibabu ya meno
☐ Mtoto wangu ana changamoto ya usalama nyumbani au anapokuwa na marafiki
☐ Je, kuna suala jingine la meno au la afya ambalo ungependa tulijadili leo?
- Kama ndiyo, tafadhali elezea: _____

Je, mtoto wao ana mzio wa au alipata athari mbaya kutokana na bidhaa zozote kati ya zifuatazo:

☐Dawa za ganzi
☐Mpira
☐ Aspirin
☐Nyingine (tafadhali bainisha):
☐Kodeini au dawa zingine za usingizi
☐ Penicillin au dawa zingine za viuadudu
☐ Vitulizo au vidonge vya usingizi
☐Madini ya Joto

_____

Tafadhali orodhesha dawa zote ambazo mwanafunzi wako anazitumia (tafadhali jumuisha dawa alizoandikiwa na daktari na asizoandikiwa na daktari):

_____

_____

Community Health Centers
SCHOOL-BASED DENTAL CENTER

Dentist Initials:

Medical/Dental History Form

Child's Name: _____ Date of birth: _____

School Child Attends: _____ Today's date: _____

Medical History

Please check any of the following that apply to your child:

☐ Asthma
☐ Cancer
☐ Hepatitis
☐ HIV/AIDS
☐ Hemophilia
☐ Diabetes
☐ Allergies
☐ Congenital Heart Defect
☐ Seizures/Epilepsy
☐ Tuberculosis
☐ Abnormal Bleeding
☐ Sinus Trouble
☐ Anemia
☐ Rheumatic Fever
☐ Handicap/Disability
☐ Heart Murmur
☐ ADHD
☐ Autism Spectrum
☐ Other (please describe): _____

Other Health Information

Please check any of the following that apply to your child:

☐ My child smokes tobacco products
- If yes, how much? _____
- Are they interested in quitting? _____

☐ My child uses recreational drugs
☐ My child consumes alcohol
☐ My child is pregnant or possibly pregnant
☐ My child has sores in their mouth that are concerning
☐ My child has had trouble with previous dental work
☐ My child has been told they need antibiotics prior to past dental work
☐ My child has safety concerns at home or with friends
☐ Are there other dental or health concerns you would like to discuss today?
- If yes, please describe:

_____

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

☐ Local anesthetics
☐ Latex
☐ Aspirin
☐ Other (please describe):
☐ Codeine or other narcotics
☐ Penicillin or other antibiotics
☐ Sedatives or sleeping pills
☐ Iodine

_____

Please list all the medications your student is taking (please include prescription and non-prescription drugs):_____

_____

Revised November 2023

Tafadhali saini hapo chini ili kuhakikisha huduma sahihi ya meno/matibabu kwa mtoto wako. Kadri ya upeo wa ufahamu wangu, maswali yaliyo kwenye fomu hii yamejibiwa kwa usahihi. Ninaelewa kwamba kutoa taarifa isiyo sahihi inaweza kuwa hatari kwa afya ya mtoto wangu. Ni jukumu langu kuitaarifu Ofisi ya mtoa huduma ya afya kuhusu mabadiliko yoyote katika historia ya matibabu ya mtoto wangu.

Sahihi ya Mzazi/Mlezi: _____ Tarehe: _____

Sahihi ya mtu anayejaza fomu hii kama sio mzazi/mlezi: _____

Simu ya Mawasiliano: _____

Idhini ya Utoaji wa Huduma

Ninatoa idhini kwa CHC – Kituo cha Meno cha Shule ya:

☐Kupanga ratiba na kumtibu mtoto wangu kwa mahitaji ya kinga na urejeshaji wa meno

☐Kupanga ratiba na kumtibu mtoto wangu kwa mahitaji ya meno ninapokuwa nimetoa ruhusa tu (kwa mdomo au maandishi)

☐Kupanga na kumtibu mtoto wangu kwa mahitaji ya meno pale ninapokuwepo tu (isipokuwa katika huduma za dharura za matibabu, meno, au afya ya akili)

Mawasiliano ya Dharura/Mabadiliko katika Hali ya Afya au Malezi

Ninakubali zaidi kwamba nitawajulisha mara moja wafanyikazi wa CHC kwa maandishi kuhusu:

- Mabadiliko yoyote katika afya ya mwili na ya meno ya mtoto wangu na
- Mabadiliko yoyote malezi ya mtoto wangu ambayo yanaathiri uwezo wangu wa kutoa idhini hii kwa niaba ya mtoto wangu.

Makubaliano kuhusu usafiri wa kwenda na kurudi kutoka CHC – Kituo cha Meno cha Shule

Jimbo la Vermont limeingia makubaliano na Wakala Maalum wa Huduma za Usafirishaji (SSTA) kutoa huduma za usafiri kwa wanafunzi wenye sifa ya kupata Medicaid kwenda na kurudi kutoka shule za Burlington na Vituo vya Meno vya CHC.

☐Kama mtoto wangu anahitaji usafiri kama ilivyoonyeshwa hapo chini, **ninawaruhusu CHC kuratibu usafiri wa SSTA kumchukua mtoto wangu kwenda na kurudi shuleni kwake kwa ajili ya huduma za meno, bila malipo kutoka kwangu.** CHC inaweza kutoa taarifa kuhusu mahitaji ya mtoto wangu kwa madhumuni ya usafiri na malipo.

Tafadhali kumbuka kwamba SSTA inaweza kutafuta malipo kutoka Medicaid kwa ajili ya huduma hizo za usafiri.

Kama mtoto wangu ataonekana mwishoni mwa siku ya shule, mtoto wangu:

☐ Atasafirishwa kurudi nyumbani kwa kutumia SSTA.

☐Ana angalau umri wa miaka 16 na anaweza kuondoka na kutembea kurudi nyumbani kwa kujichunga wao wenyewe.

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 health care provider's office of any changes in my child's medical history.

Parent/Guardian Signature: _____ Date: _____

Signature of person completing form if not parent/guardian: _____

Contact Phone: _____

Consent to the Provision of Services

I authorize CHC – School-Based Dental Center to:

☐ Schedule and treat my child for preventative and restorative dental needs

☐ Only schedule and treat my child for dental needs when I have given permission (verbal or written)

☐ Only schedule and treat my child for dental needs when I am present (except in the care of a medical, dental, or mental health emergency)

Emergency Contact/Changes in Health Status or Custody

I further agree that I will promptly inform CHC staff in writing of:

- Any change in my child's physical or dental health and
- 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 CHC – School-Based Dental Center

The State of Vermont has contracted with Special Services Transportation Agency (SSTA) to provide transportation services for Medicaid eligible students to and from Burlington's schools and the CHC Dental Centers.

☐ If my child needs transportation as indicated below, **I consent to having CHC schedule SSTA transportation take my child to and from their school for dental services, at no cost to me.** CHC may disclose information about my children's need for transportation and payment purposes.

Please note 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:

☐ Should be transported home via SSTA.

☐ Is at least 16 years of age and may leave and walk home under their own supervision.

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

Parent/Guardian Signature: _____ Date: _____

Signature of person completing form if not parent/guardian: _____

Contact Phone: _____

Mimi (jina la mzazi au mlezi) _____ nimesoma nyenzo za hapo juu na kuelewa maana yake. Sahihi yangu ni uthibitisho kwamba nimepitia fomu hii, nimeelewa taarifa na idhini ya hatua zote zilizobainishwa hapo juu. Pia sahihi yangu inathibitisha usahihi wa taarifa iliyotolewa kwenye fomu hii.

Sahihi ya Mzazi/Mlezi: _____ Tarehe: _____

Sahihi ya mtu anayejaza fomu hii kama sio mzazi/mlezi: _____

Simu ya Mawasiliano: _____

Community Health Centers

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:

- 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 consent to the use of SDF as prescribed by the CHC provider:

Yes_____ No_____

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

Signature of Parent/Guardian_____Date_____