WILLIAMSPORT AREA SCHOOL DISTRICT
OFFICE OF STUDENT SERVICES
DEPARTMENT OF SCHOOL HEALTH SERVICES

Dear Parent/Guardian,

The Williamsport Area School District and River Valley Dental Center have partnered to develop a school dental program. In this program, the River Valley Dental Center brings the dental bus to provide onsite dental care to our students. We are currently accepting applications for this program for students in grades K-12.

If you are interested in having your child participate in this program, please complete the attached paperwork and return it to your child's school. If your child already attends the River Valley Dental Center School Program and you did not complete the forms for this school year, please complete the attached forms.

This program is not for students who receive care from their family dentist. Please **do not** complete the attached forms if your child has a family dentist.

Note: Pennsylvania Department of Health requires students in Kindergarten, 3rd, and 7th grade to have a dental examination.

If you need any assistance with the paperwork or have any questions, please feel free to call me at 570-327-5500 ext. 40316.

Sincerely,

Corrina Gnoffo, BSN, RN, CSN

WASD Dental Program Coordinator

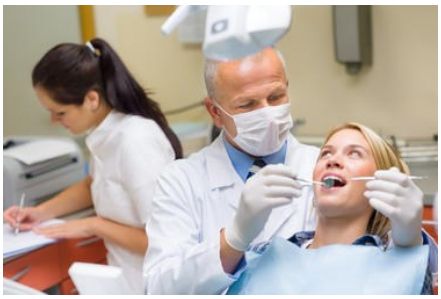
River Valley Health & Dental Center Dental School Program

River Valley Health & Dental Center provides dental services to students within local school districts. Students enrolled will be seen by staff at their respective school on our mobile care unit. Any student within the district is eligible for the program.

Dental Services Provided:

- Dental Exams
- Dental X-Rays (Cavity Detection X-Rays)
- Instructions for Oral Hygiene, Brushing, Flossing, and Diet
- Fluoride Varnish Treatments
- Prophylaxis (Dental Cleanings)
- Preventative Treatment (Sealants) - A thin coating painted on the chewing surfaces of teeth which forms a protective shield over the enamel of each tooth to prevent decay.
- Restorative Treatment (Dental Fillings) **Based on Dentist Availability**—Treatment to restore the function, integrity, and morphology of missing tooth structure resulting from caries or external trauma.

*All families will have the ability to schedule appointments at our other locations for additional care as needed.



Communication is a very important aspect provided to the parent(s)/guardian(s) of students enrolled in the Dental School Program. Notification is given prior to all appointments and follow-up calls are made by River Valley Health & Dental Center staff which include information regarding referrals and/or additional treatment needed.

*Enrollment forms must be completely filled out in order to serve the students. These forms will collect insurance information and services will be billed accordingly. The responsible party is expected to pay the balance, if any, after insurance. If you do not have insurance, we offer a sliding fee scale discount program which discounts services based on income and household size using the Federal Poverty Guidelines.

If you are interested in enrolling your child(ren) in the program,
please fill out the attached enrollment and consent form and return them to the school.

Laura Bierly, RDH, PHDHP
Outreach Dental Hygienist
570-567-5400 ext. 1320
laurab@rvhdc.org

The mobile unit is funded in part by:
*the **Williamsport Lycoming Community Fund at First Community Foundation Partnership of Pennsylvania.***

River Valley Health & Dental
Your Center for Care

Dental School Program Enrollment Form
(PLEASE PRINT)

Patient's Last Name:_____ First Name:_____ MI: _____

Sex:_____ Date of Birth:_____ Social Security #:_____

Address (Include Apt. #):_____ City: _____ State:_____

Zip Code: _____ Pharmacy: _____ School Child Attends:_____ Grade_____

# of Persons in Household:_____ Monthly Household Income: _____

DENTAL INSURANCE CARRIER:_____ POLICY NUMBER:_____

Gender Identity:
- ☐ Male ☐ Female
- ☐ Neither Exclusively Male nor Female
- ☐ F to M/Transgender Male/Trans Man
- ☐ M to F/Transgender Female/Trans Woman
- ☐ Refused to Report
- ☐ Other_____

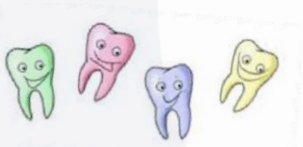
Sexual Orientation:
- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Lesbian/Gay/Homosexual
- ☐ Unknown Refused to Report

Housing Status:
- ☐ Not Homeless
- ☐ Doubling Up
- ☐ Homeless Shelter
- ☐ Public Housing
- ☐ Street
- ☐ Transitional

Race:
- ☐ White
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ American Indian/Alaska Native
- ☐ Other Pacific Islander
- ☐ Declined to Answer

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Declined to Answer

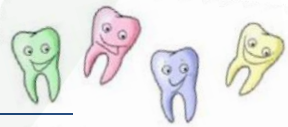
Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Chinese
- ☐ German
- ☐ Italian
- ☐ Japanese
- ☐ Other
- ☐ Sign Language



MEDICAL HISTORY: (Please attach additional sheet if needed)

Surgeries/Hospitalizations: _____

Illnesses: _____



Medications: _____

Allergies: _____

Primary Care Provider:_____ Date of Last Visit:_____

PARENT/GUARDIAN CONTACT INFORMATION:

NAME: _____

PHONE:_____ SECONDARY PHONE:_____

EMAIL ADDRESS: _____

SIGN & DATE

_____

SIGNATURE DATE

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River Valley Health & Dental
Your Center for Care

Dental School Program Consent for Treatment

471 Hepburn Street
Williamsport, PA 17701

Patient (Child's) Name: _____ Date of Birth: _____

This authorization and consent is intended to cover the delivery of dental care services to my minor child (referenced above) by RVH&DC.

- I understand that this authorization will remain in effect with no expiration, unless revoked. I may revoke this authorization at any time, following the procedures outlined in the RVH&DC **Notice of Privacy Practices**.
- I understand that by signing this authorization, I am giving RVH&DC the authority to provide treatment, including administration of medication, as necessary in the provider's judgment.
- I understand that the practice of medicine is not an exact science and no person has made a guarantee about the outcome of such care.
- I reserve the right to refuse a specific treatment at any time.

By signing below, I hereby consent to treatment by all RVH&DC providers, staff and others as may be involved in the dental care of my child in ways they judge are beneficial, to include exams, medication, and other dental treatments. Further, I understand that such treatment may be provided outside of my physical presence by the signing this consent.

I understand I have full access to the following documents at any time online at www.rivervalleyhealthanddental.org:

- RVH&DC Notice of Privacy Practices
- Patient Rights and Responsibilities

At any time, I can request a hard copy of these documents by calling River Valley Health & Dental.

Parent/Legal Guardian Name: _____ **Phone:** _____

Parent/Legal Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____