Dear Parent(s)/Guardian(s),
March 10th, 2025

The Erie County Health Department/Erie County Community Health Center has partnered with Edison Local School District to provide onsite school-based dental services, physicals, and age-appropriate immunizations on selective dates for the 2025-2026 school year. Dental services will be provided on the Erie County Health Department/Erie County Community Health Center's Mobile Dental Vehicle which is designed and outfitted as a Mobile Dental Center to provide comprehensive and quality dental care in the community setting. Age-appropriate immunizations and school and/or sports physicals will be offered on site for your convenience. All services rendered will be billed to insurance, if applicable. Reduced out of pocket costs and free services are available. No child will be denied services due to inability to pay.

Location:	Edison Middle School	Edison High School
Date:	Wednesday, May 21st, 2025	Thursday, May 22nd, 2025
Time:	9 am – 2 pm	9 am – 2 pm

What to expect?

Services are provided at your child's school for convenience. Dental and medical services are provided by a team of licensed dentists, dental assistants, dental hygienists, nurses, and medical providers.

What is the follow-up?

According to the American Dental Association, children and adults should receive a dental cleaning every six months to maintain healthy teeth and gums. Before and after a student is seen for medical or dental services, a staff member from the Erie County Community Health Center will reach out to the parent/guardian and review details pertaining to the student's appointment and recommended follow-up care (if they are a minor).

How do I make an appointment for my child?

As dates for services are announced and for your convenience, please call the Erie County Community Health Center Centralized Scheduling office at 567-867-5174 to pre-register your child's appointment. Walk-in appointments are available.

What paperwork do I need for my child to participate?

Please complete and turn in the SBHC Consent Form along with a copy of the parent/guardian's photo ID (for minor children) and insurance card, if applicable. **If the Ohio High School Athletic Association (OHSAA) pre-participation physical evaluation form is required by the school, please complete the history section and athletes with disabilities form, if applicable, along with the parent/guardian signature portion.** Please have students turn in completed forms to the school. Completed consent forms and a copy of the student's or parent/guardian's photo ID and insurance card will be given to the Erie County Community Health Center staff prior to the scheduled appointment. It is not necessary for the parent/guardian to attend the appointments, but you are welcome.

For any questions, please contact:

Chesney Iannello, RN
Primary Care and Clinical Services Director
(419) 626-5623 Ext: 5227
ciannello@echdohio.org

Erie County Health Department/Erie County Community Health Center

School Based Health Center Consent Form

Name of Student _____ Date of Birth _____ Grade _____

I understand that the Erie County Community Health Center will provide health services. One consent form per student must be signed annually and on file at the health center for the student to receive these services. By marking "yes" I consent to the following:

☐ **Yes!** I consent for this form to act as **valid informed consent** for treatment at all sites of the Erie County Community Health Center.

☐ **Yes!** I consent for my child to receive ☐ Medical Care and/or ☐ Mental Health* care through the School Based Health Center (examples: physical exams, evaluations of injuries, vaccines, chronic disease management, referrals, counseling services etc...)

☐ **Yes!** I consent for my child to receive all required and recommended vaccinations unless otherwise specified.
List the name(s) of any vaccine(s) you do *NOT* want your child to receive _____.
Has your child ever had a serious reaction from a vaccine? ☐ No ☐ Yes If so, what _____.

Disease	Vaccine	Disease	Vaccine	Disease	Vaccine
Polio	IPV**	Measles	MMR**	Influenza/Flu	Influenza Vaccine
Chicken Pox	Varicella**	Mumps	MMR**		
Hepatitis B	Hep B**	Rubella	MMR**	**CHILDREN UNDER**	**5 YEARS OLD**
Tetanus	Tdap/Td/Dtap**	Meningococcal Meningitis	MCV4	Severe Diarrhea	Rotavirus
Diphtheria	Tdap/Td/Dtap**	Human Papillomavirus	HPV9	Bacterial Disease	HIB
Pertussis	Tdap/Td/Dtap**			Pneumonia	PCV13

Vaccines marked with (**) are required for school.

☐ **Yes!** I consent for my child to receive **Dental Care** through the School Based Health Center.
(examples: cleanings, x-rays, sealants, fluoride, exams)
***Parent/guardian of minor must be present for fillings, endodontic procedures and/or extractions**

I hereby authorize the School Based Health Center to provide the services as indicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served regardless of the ability to pay. I hereby authorize the School Based Health Center staff members to release any medical records required by the insurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, the School Based Health Center staff members will use and share Personal Health Information for 1.) Treatment of my child's health conditions and maintaining the continuity of my child's care, 2.) Payment for health services provided to my child, and 3.) Routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices documentation is available to me at the location(s) my child receives his/her health care services and on the Erie County Health Department/Erie County Community Health Center website.

Parent/Guardian Signature _____ Print Name _____ Date _____

*Note: In accordance with Title X law, parental consent is *not* required for health services for individuals age 14 and older for medical treatments for venereal disease or HIV, diagnosis of pregnancy, or preventative services.

I hereby authorize the release of medical records to and from the following facilities to assist in the treatment and/or for continuity of care of my child: (check all that apply)

☐ The school to release records on a "need to know basis" to the School Based Health Center. (example: immunization record, class schedule, parental contact, address, phone number, medical/behavioral health conditions, health screenings, medications, health care plans, attendance information, etc.)

☐ My child's primary care physician to release any requested records to the School Based Health Center.
Physician's Name/Office _____ Phone Number _____

☐ My child's dentist to release any requested records to the School Based Health Center.
Dentist Name/Office _____ Phone Number _____

☐ The School Based Health Center to release records to my child's primary care physician and/or dentist as listed above.

Parent/Guardian Signature _____ Print Name _____ Date _____

Name of Student _____ Date of Birth _____ Grade _____

Parent/Guardian Information

Mother/Guardian _____ DOB_____ Home Phone _____ Alt Phone _____
Father/Guardian _____ DOB_____ Home Phone _____ Alt Phone _____
Parent(s)/Guardian Address _____

Health Insurance (Please circle and complete, if applicable)

Medical Insurance: Private Insurance Medicaid Uninsured
Insurance Policy Holder's Name: _____ Insurance Policy Holder's DOB: _____
Insurance Policy Number _____ Insurance Policy Group Number _____

Dental Insurance: Private Insurance Medicaid Uninsured
Insurance Policy Holder's Name: _____ Insurance Policy Holder's DOB: _____
Insurance Policy Number _____ Insurance Policy Group Number _____

Student's Health History

Primary Care Physician: _____ Phone: _____ Date of Last Exam: _____
Primary Dentist:_____ Phone: _____ Date of Last Exam: _____

Allergies to medications, foods, bee stings, etc.....: _____
Current medications child is taking:

_____

Important health history: (Pregnant, history of cancer, tumors, seizures, diabetes, tuberculosis, and heart murmurs, etc...)

_____

Has your child ever been hospitalized overnight in the past year? ☐ Yes ☐ No If yes, why? _____
Has your child had surgery in the past year? ☐ Yes ☐ No If yes, please describe: _____

Student/Family History

	Yes	No	Unsure	Age of onset	Student	Mom/Dad	Brother/Sister	Grandparent
Alcohol/Drug use								
Anesthetic Allergy								
Anemia								
Artificial Heart Valve/Joint								
Asthma								
Blood Disorder/Sickle Cell Anemia								
Cancer								
Diabetes								
Depression/Anxiety								
Heart attack/Stroke **before** 55 years old								
Hemophilia								
High Blood Pressure								
Kidney Disease								
Learning Disability/special education								
Seizures/epilepsy								
Tobacco use								
Tuberculosis/lung disease								

Please add anything about your child's health that you feel would be helpful information that has not been inquired.

_____