Waynesboro Public Schools
Name of School: _____
Date of Dental Clinic: _____

Our school is partnering with the **Augusta Regional Dental Clinic (ARDC)** and will welcome their school based oral health program (ORCAS) on _____. Enrolled students will receive an examination, x-rays, and, if applicable fluoride treatment and sealants with no out of pocket cost for the families or school. This examination will determine if further preventive or restorative dental work is needed. If your child is found to be in need of follow up services, additional information will be sent to you and you may be able to schedule an appointment with the ARDC.

If you would like your child to participate in this program, please complete and sign the lower section of this letter and return it to school as soon as possible. If you currently take your child to see a dentist every 6 months for routine care, we encourage you to continue to seek care at that office and you do not need to complete this form. Please do not hesitate to contact the school for additional information or answers to specific questions.

By completing this form, I, the legal guardian, authorizes Augusta Regional Dental Clinic to use and disclose the protected health information and dental records to the child's school nurse and/or nursing staff. In addition, I consent to the use and disclosure of the minor's protected health information to carry out payment activities in connection with this claim if indicated. I authorize direct payment of dental benefits directly to ARDC.

To obtain a full written disclosure of Augusta Regional Dental Clinic's Health Insurance and Portability & Accountability Act (HIPAA) please call the clinic directly at 540-221-6635.

- My child is enrolled in the "Smiles for Children" dental program (Medicaid, Famis, Famis Plus, Optima & Virginia Premier). Medicaid Number: _____
- My child has private dental insurance.
- My child has no dental insurance.

Student's Name: _____

Address: _____

Date of Birth: _____ Grade: _____

Gender: _____ Teacher: _____

Phone Number: _____ Known Allergies: _____

Parent/Legal Guardian Signature: _____