



## Children's Dental Clinic School Nurse Check-Off List

WellPartners provides free dental care to qualifying children attending Richland and Lexington County Public Schools.

### **TO QUALIFY:**

Children automatically qualify if they have free or reduced lunch.

Children must not be eligible for Medicaid.

Children must not have dental insurance.

### **NEW ELIGIBLE CHILDREN:**

Nurses must first verify eligibility. Do not give forms to children to take home to their parents until you know they are eligible.

### **PARENTS:**

Complete and sign their child's portion of the Certification/Referral Form and their child's Health History (front and back).

### **NURSES:**

Please sign and date child's Certification/Referral Form and include your contact phone number. Schedule the first appointment after all information is completed by parent. Please inform parents that all children are seen in the order in which they were signed in. Inform parents that they are asked to remain in the waiting area while their child is having dental treatment.

### **RECERTIFYING ELIGIBLE CHILDREN:**

Each child must be re-qualify for eligibility every two years. The WellPartners staff will notify parents to contact school nurse and the school nurse will go through the original process of eligibility.

Tooth decay affects children in the United States more than any other chronic infectious disease. Untreated tooth decay causes pain and infections that may lead to problems; such as eating, speaking, playing and learning.

The good news is that tooth decay and other oral diseases that can affect children are preventable. The combination of dental sealants and fluoride has the potential to nearly eliminate tooth decay in school-age children.

*Centers for Disease Control and Prevention (CDC), 2012*

**Your children may qualify for FREE dental services through WellPartners. Contact your child's school nurse for further information.**

## **Information for Mothers:**

Poor oral health of the mother, including dental decay and periodontal disease before and during pregnancy, has been linked to poor birth and pregnancy outcomes such as preterm birth and low birth-weight. In addition, ensuring good oral health for women during the perinatal period plays a vital role in promoting the oral health of her children after birth.

Increasing evidence suggests that maternal gingivitis and periodontitis may be a risk factor for preterm birth and other adverse pregnancy outcomes.

*National Maternal and Child Oral Health Resource Center (NMCOHRC), 2008  
Journal of American Dental Association (JADA), 2012*

Contact the Palmetto Health-Healthy Start Program for further information. 803-296-3780 or 800-249-4340





<b>Children's Dental Clinic</b>	
WellPartners Adult & Children's Dental Clinics Lexington County Health Department Red Bank Crossing 1070 South Lake Dr., Suite B Lexington, SC 29073 Phone: 803-888-3271	WellPartners Children's Dental Clinic Richland County Health Department 2000 Hampton Street, Suite 4090 Columbia, SC 29204 Phone: 803-888-1590

## CHILD'S HEALTH HISTORY

The following questions and answers are for our records only and will be considered confidential.

Last medical exam: \_\_\_\_\_ Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Is your child now under a physician's care?  Yes  No  
 If yes, why? \_\_\_\_\_

Is your child currently taking medications?  Yes  No

If yes, what medications? \_\_\_\_\_

Is your child a hemophiliac (bleeder)?  Yes  No

Has your child been hospitalized?  Yes  No

If yes, reason for hospitalization: \_\_\_\_\_

Indicate if your child has, or had, any of the following

### CONDITIONS—DISEASES—TREATMENTS

- |                                     |                              |                             |                            |                              |                             |
|-------------------------------------|------------------------------|-----------------------------|----------------------------|------------------------------|-----------------------------|
| Anemia                              | <input type="checkbox"/> yes | <input type="checkbox"/> no | Sinus Problems             | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Asthma                              | <input type="checkbox"/> yes | <input type="checkbox"/> no | Thyroid Condition          | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Seasonal Allergies/Hay Fever        | <input type="checkbox"/> yes | <input type="checkbox"/> no | Kidney or Liver Disease    | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Diabetes                            | <input type="checkbox"/> yes | <input type="checkbox"/> no | Fainting or Dizzy Spells   | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Hepatitis or Jaundice               | <input type="checkbox"/> yes | <input type="checkbox"/> no | Nervous Habits/Problems    | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Epilepsy or Seizures                | <input type="checkbox"/> yes | <input type="checkbox"/> no | Eating Disorders           | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Stomach or Intestinal Bleeding      | <input type="checkbox"/> yes | <input type="checkbox"/> no | High or Low Blood Pressure | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Prolonged bleeding from cut/surgery | <input type="checkbox"/> yes | <input type="checkbox"/> no | Stroke                     | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Abnormal Heart Disease/Defect       | <input type="checkbox"/> yes | <input type="checkbox"/> no | Venereal Disease           | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Rheumatic Fever or Heart Disease    | <input type="checkbox"/> yes | <input type="checkbox"/> no | Radiation Treatment        | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Heart Murmur                        | <input type="checkbox"/> yes | <input type="checkbox"/> no | Blood Transfusion          | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Tuberculosis (TB)                   | <input type="checkbox"/> yes | <input type="checkbox"/> no | AIDS/HIV Positive          | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Arthritis                           | <input type="checkbox"/> yes | <input type="checkbox"/> no | Malignancies               | <input type="checkbox"/> yes | <input type="checkbox"/> no |

Indicate if your child has, or had, any of the following

### ALLERGIES - REACTION

