KENTUCKY STATE POLICE

TROOPER ISLAND, INC. KSP [ ]

2020 CAMPER APPLICATION FORM NON KSP [ ]

Date _____ **Trooper:** _____ **Post Number** _____

Post Commander: _____

APPLICATION MUST BE DELIVERED TO TROOPER ISLAND WITH CAMPER

CAMPER NAME: _____ _____ _____
(First) (Middle) (Last)

PREFERRED NAME (Goes By) _____ Gender: Male or Female _____

ADDRESS: _____ _____ _____ _____
(Street) (City) (State) (Zip)

Email Address: _____

Soc. Sec #: _____ Date of Birth _____-_____- _____ Age _____

School Attended: _____ Grade camper will be in when school starts: _____

PARENT / GUARDIAN'S NAME: (first) _____ (mi) ____ (last)_____

PHONE: Home: ( ) _____-_____ Work: ( ) _____-_____ Cell: ( ) _____-_____

RELATIVE OR NEIGHBOR CONTACT

(MY CHILD CAN BE RELEASED TO THIS PERSON IF I AM NOT AVAILIBLE)

NAME: (last) _____ (first) _____ (m.i.)_____

ADDRESS: (street)_____ (city) _____ (zip) _____

PHONE: Home: ( ) _____-_____ Work: ( ) _____-_____ Cell : ( ) _____-_____

Has camper attended a summer camp before: ☐ Yes ☐ No Where: _____ When: _____

Can child swim: ☐ Yes ☐ No _____

ACTIVITIES THAT THE CAMPER <u>CANNOT</u> PHYSICALLY PARTICIPATE IN

☐ **Swimming** ☐ **Running** ☐ **Other:** _____

I AGREE TO OBEY ALL RULES AND REGULATIONS ON THE CAMP AND WILL COOPERATE WITH THE DIRECTIVES OF THE CAMP DIRECTOR, COUNSELORS AND STAFF.

Camper Signature: _____ Date: _____

<u>I GIVE THE KENTUCKY STATE POLICE AND TROOPER ISLAND , INC. PERMISSION TO ACCEPT MY CHILD AS A CAMPER AT TROOPER ISLAND AND FURTHER RELEASE THE KENTUCKY STATE POLICE AND TROOPER ISLAND, INC., THEIR EMPLOYEES AND VOLUNTEERS OF ANY AND ALL LIABILITY.</u>

Signature of parent / guardian _____ Date _____

KENTUCKY STATE POLICE
TROOPER ISLAND, INC.
2020
AUTHORIZATION TO USE PHOTOGRAPHS
AND
AUDIO VISUAL RECORDINGS

I _____, parent of _____,
(Please print) (Please print)

who has been selected to attend a camping session at Trooper Island Inc., do hereby grant permission to Trooper Island Inc., its officers, agents, employees, and other officials or designees, the right to use photographs and audio or visual recordings of my child taken or produced while my child attending or in the application process for attendance at Trooper Island.

I further authorize the use of the photographs and audio or visual recordings, or reproductions thereof, to be used in written, video, website, or other medium used to promote Trooper Island, Inc. and its programs. This authorization includes both use in domestic and foreign markets or exchanges.

In my own behalf, and in behalf of my child, I relinquish and give to Trooper Island, Inc., all right, title, and interest that my child or I may have any photograph, audio, or visual recording, or reproduction thereof, and further grant Trooper Island, Inc., the right to give, sell, transfer, and exhibit any photograph, audio or visual recording or reproduction thereof, to any responsible individual, business firm or publication, or to any of their assignees.

I clearly understand that neither I, nor my child, will receive any compensation for the above grant authorization.

Signature of parent / guardian _____Date _____

Witness: _____ Date _____

AUTHORIZATION FOR CAMP ATTENDANCE PHOTO CARD

Camp Attendance Photo Card

Yes ___ I give permission for my child to have a Camp Attendance Photo Card made.

No ___ I do not give permission for my child to have a Camp Attendance Photo Card made.

Card will be given to child for them to bring home.

Signature of parent / guardian _____Date _____

Income Eligibility Form
For the Summer Food Service Program
Trooper Island Camp Inc
PO Box 473 Albany, KY 42602

Part 1. Children enrolled in Camp or Closed Enrolled Sites

Names (First, Middle Initial, Last)	SNAP, TANF or FDPIR case # (if any). **Skip to Part 4 if you listed a case #.**

Part 2. Foster Child

FOSTER CHILD YES___ NO___ IF YES, INDICATE COURT ORDERED CASE #_____ AND ATTACH DOCUMENTATION.
PAO/Trooper_____ Contact Phone#_____

PART 3 TOTAL HOUSEHOLD GROSS INCOME – PLEASE TELL US HOW MUCH AND HOW OFTEN

A. NAME EVERYONE INCLUDING CHILDREN	B. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: **Example:** $100/monthly $ $100/twice a month $100/Every other week $100/Weekly				
	EARNINGS FROM WORK BEFORE DEDUCTIONS	WELFARE, CHILD SUPPORT, ALIMONY	SOCIAL SECURITY, PENSIONS, RETIREMENT	ALL OTHER INCOME	C. CHECK If No Income
1	$ /	$ /	$ /	$ /	
2	$ /	$ /	$ /	$ /	
3	$ /	$ /	$ /	$ /	
4	$ /	$ /	$ /	$ /	
5	$ /	$ /	$ /	$ /	
6	$ /	$ /	$ /	$ /	
7	$ /	$ /	$ /	$ /	
8	$ /	$ /	$ /	$ /	

Part 4 Signature and Social Security Number (Adult must Sign)

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Signature _____ **Print Name** _____ **Date**_____

Address _____ **Phone#** _____

Last four digits of Social Security Number __ __ __ __ ☐ **I do not have a Social Security Number**

Part 5 Participant's ethnic and racial identities (optional)

Mark on ethnic identity:	Mark one or more racial identities:
☐ Hispanic or Latino ☐Not Hispanic or Latino	☐ Asian ☐ White ☐ Black or African American ☐American Indian or Alaska Native ☐Native Hawaiian or Other Pacific Islander

KSP PAO AND SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12
Total Household Income $ _____ Per: ☐Week, ☐Every 2 Weeks, ☐Twice a Month, ☐Month, ☐Year
Household Size _____
Categorical Eligibility: ___ Date Withdrawn:_____ Eligibility: Free___ Reduced ___ Denied ___
Reason:_____
Temporary: Free___ Reduced___ Time Period:_____ (expires after_____days)
Public Affair's Officer Signature:_____Date:_____
Post Commander Signature:_____Date:_____
Trooper Island Commander Signature _____Date:_____

PRIVACY ACT STATEMENT

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington DC 20250-9410 or call (866) 632-9992 (Voice) Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339: or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

September 13, 2019

Dear Parent /Guardian:

Trooper Island Camp takes part in the Summer Food Service Program, a U.S. Department of Agriculture program operated in Kentucky by the Kentucky Department of Education. This sponsor receives federal dollar to help pay for food served to all enrolled children. The amount is based on rates set by the federal government.

Thank you for filling out an application and helping the sponsor provide nutritious meals and snacks that can help your child grow stronger and healthier. If you any questions about the Summer Food Service Program application, please give me a call at 270-433-5422.

Sincerely,

MSTPR. Jonathan Biven

MSTPR Jonathan Biven
Camp Director/Commander
Trooper Island Camp

Kentucky State Police

Trooper Island Inc.

2020 Camper Medical History and Release

(To be completed by Parent/Guardian)

Camper Name _____ _____ _____
(Last) (First) (Middle)

Social Security # - _____ Date of Birth ____ - ____ -_____ Date of Last Immunization _____

Insurance Information: Is the camper covered by Family Medical/Hospital Insurance? ☐ YES ☐ NO
If so indicate Carrier or Plan Name _____ Group # _____
Or does Camper have a Medical Card ☐ YES ☐ NO If so Card#_____

Currently Taking Medication? ☐ YES ☐ NO If Yes List Medications and Complete Medication Schedule on back of this Form.

Has Child had lice within the past year? ☐ Yes ☐ No If Yes when: _____

Check any conditions that apply: MAKE SURE YOUR CHILD HAS THEIR MEDICATION WITH THEM

Recent injury or Illness		Sleep Walking		History of Bedwetting	
Frequent Headaches		Ever Had a Head Injury		Been Knocked Unconscious	
Wear Glasses/Contacts		Frequent Ear Infections		Ever had Seizures	
Have High Blood Pressure		Diagnosed with a Heart Murmur		Skin Problems	
Have Diabetes		Has Asthma		Had Mononucleosis in the Past 12 Months	
Ever had Surgery		Menstrual Cycle		Depression	
Ever been Hospitalized		Ever Had Eating Disorder		Ever had Emotional Difficulties	
Nose Bleeds		Heart Condition		Ulcer	
Sinus Trouble		Convulsions		Fainting Spells	
Speech Impediment		Deaf or Hard of Hearing		ADD/ OCD	
ADH/ADHD		ODD		Head lice	
Anxiety		*Other Not Listed			

*Explain Not Listed Conditions: _____

Please List All Known Allergies:

Medication Allergies_____
Food Allergies _____
Other Allergies _____

Family Physician _____ Phone Number _____

Parent or Guardian Emergency Contact: _____

Phone Number _____ **Cell Phone Number** _____

Emergency Contact other than Parent or Guardian: _____

Phone Number _____ Cell Phone Number _____

Parents/Guardian: When we assume the responsibility of your child, we put his/her safety and health above all other considerations. Doctors are not permitted, by law to perform surgery and administer many other treatments to a child without the parent's consent. If the need arises, every effort will be made to allow you to make such decisions, but if circumstances make it necessary, you would want us to be free to act on behalf of your child, according to the best advice available. To make this possible, we ask that you sign the following statement and return it with the application.

I HEREBY AUTHORIZE THAT PERSONS AND AGENCIES ENTRUSTED WITH THE CARE OF MY CHILD WHILE ENROUTE TO AND FROM AND WHILE AT TROOPER ISLAND CAMP, WHICH IS OPERATED BY THE KENTUCKY STATE POLICE, TROOPER ISLAND, INC., TO FOLLOW THE ADVISE OF THE BEST AVAILABLE MEDICAL AUTHORTIES AND ADMISISTER ANY TREATMENT, INOCULATIONS, MEDICINES AND SURGICAL PROCEEDURES DEEMED NECESSARY TO MY CHILD'S SAFETY. I ALSO AUTHORIZE THE TROOPER ISLAND CAMP STAFF TO ADMINISTER ANY MEDICATIONS, AS DEEMED NECESSARY.

Signature of parent/guardian _____ Date _____

Trooper Island 2020 Camper Medication Schedule

Camper's Name _____

INSTRUCTIONS: The following **must be completed for each prescription** that is to be taken by your child during camp. Please list medication in the order in which they are to be taken. **This includes inhalers**. **ALL MEDICATION SHALL BE IN THEIR ORiGINAL PRESCRIPTION BOTTLES. ANY MEDICATION NOT IN THEIR ORIGINAL BOTTLE SHALL NOT BE ADMINISTERED.**

List of Medications 1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

Breakfast

Medication Name	Dosage	Special Instructions
1)		
2)		
3)		
4)		
5)		
6)		

Lunch

Medication Name	Dosage	Special Instructions
1)		
2)		
3)		
4)		
5)		
6)		

Dinner

Medication Name	Dosage	Special Instructions
1)		
2)		
3)		
4)		
5)		
6)		

Bedtime

Medication Name	Dosage	Special Instructions
1)		
2)		
3)		
4)		
5)		
6)		

Other Notes: _____

_____

_____

KENTUCKY STATE POLICE
TROOPER ISLAND, INC.
CAMP INFORMATION FORM
(*To Be Retained By Parent /Guardian*)

Dear Parent/Guardian,

This application packet is for 2020 Trooper Island Camp. Please retain this page for your information. Please make sure all other forms are completed and returned to the Kentucky State Police. In case of and emergency Trooper Island Camp # (270) 433-5422 or contact the number below and have them contact Trooper Island

Public Affairs Officer _____ Post _____ Phone _____

I. Travel Information

You will be picked at _____on Monday, _____, 2020 at approximately _____a.m.

You will return home on Friday, _____, 2020 at approximately _____p.m.
The camper will be transported to and from camp on the Trooper Island Bus. The return trip from Trooper Island will depend on weather conditions. Departure time is scheduled between 12:00 p.m. and 1:00 p.m. C.D.T.

II. Medication

Please pack any type of medication (prescription or non-prescription), in its proper container. *If you identify your child as having a condition such as ADD/ADHD or similar condition, make sure that the proper medication is sent with your child.* **Campers are not allowed to keep medication on their person.**

III. Things to Bring

- ✓ **Minimum** of five (5) changes of clothing, which should include shorts and shirts and at least one (1) pair of long trousers.
- ✓ **Male**: Swim trunks or shorts – **Female**: Swimsuit should be One Piece or a Tankini.
- ✓ Necessary underclothes
- ✓ Jacket
- ✓ Towels, washcloths, toothbrush, toothpaste, comb / brush, shampoo, deodorant and soap.
- ✓ Cap or visor
- ✓ Tennis shoes (old/comfortable) Socks, and Flip Flops or Shower Shoes.
- ✓ May bring a flashlight, but not required
- ✓ Small amount of money (no more than $5.00). This is to be used in case the bus stops while enroute to or from the island.

Do Not Bring

- ➢ Sleeping Bag or any other type of bedding
- ➢ Excess luggage
- ➢ No type of knife, firearms, fireworks, lighters, electronic device or component, jewelry, makeup, tobacco products, etc.
- ➢ No food / drinks or snacks
- ➢ **Do Not send cell phones with camper**
- ➢ Any item found will be confiscated by camp director or designated KSP employee
- ➢ Trooper Island is not responsible for any of these items if lost or damaged.

Letter To Households
National School Lunch Program/School Breakfast Program

Dear Parent/Guardian:

Trooper Island Camp takes part in the Summer Food Service Program, a U.S. Department of Agriculture program operated in Kentucky by the Kentucky Department of Education. This sponsor receives federal dollars to help pay for food served to all enrolled children. The amount is based on rates set by the federal government.

*If you now get Food Stamps or Kentucky Transitional Assistance (K-TAP) for your child, your child can get free lunch/breakfast.
*If your total household income is at or below the amounts on the Income Chart, your child may get free or reduced price lunch/breakfast.
*If you have a foster child, that child may be eligible for benefits regardless of your income.

INCOME CHART FOR FREE/REDUCED PRICE MEALS
(Effective from July 1, 2019 to June 30, 2020)

Household Size	Annual	Monthly	Twice per Month	Every Two Weeks	Weekly
1	15782	1,316	658	607	304
2	21,398	1,784	892	823	412
3	27,014	2,252	1,126	1,039	520
4	32, 630	2,720	1,360	1,255	628
5	38,246	3,188	1,594	1,471	736
6	43,832	3,656	1,828	1,687	844
7	49,478	4,124	2,062	1,903	952
8	55,094	4,592	2,296	2,119	1,060
For each additional family member add	5,616	468	234	216	108

HOW TO APPLY

To get free/reduced price meals for your child, carefully complete the application and return it to the school. If you now get food stamps or K-TAP for your child, the application must have the child's name, your food stamp or K-TAP case number and the signature of an adult household member. If you do not list a food stamp or K-TAP case number, the application must have the names of everyone in the household, the amount of monthly income each household member now gets, where it comes from, the Social Security number of the household member who signs the application or the word "none" if the member does not have a Social Security number. An application that is not complete cannot be approved.

OTHER INFORMATION:

***VERIFICATION**: Your eligibility may be checked by school officials at any time during the school year. You may be asked to send information to prove that your child should get free or reduced price meals.

***FAIR HEARING**: If you do not agree with the school's decision on your application or the results of verification, you may wish to discuss it with the school. You also have the right to a fair hearing. You can do this by calling or writing the following official:

NAME:_____PHONE:_____

ADDRESS:_____

***REPORTING CHANGES:** If your child gets free or reduced price meals based on income information, you must tell the school if your household size decreases or your income increases by more than $50 per month or $600 per year. If your child gets meals based on K-TAP/food stamp information, you must advise the school if you no longer get K-TAP or food stamps for your child. You may then complete another application with up-to-date information.

***CONFIDENTIALITY:** The information that you give will be used to determine eligibility for free or reduced price meals and may be used to determine eligibility for **Health Insurance** under Medicaid or the Children's Health Insurance Program (CHIP). If you are interested in receiving **Health Insurance** for your child under Medicaid or CHIP check **"Yes"** in **Part 4** and sign the name of a parent/guardian.

***"In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer."**

Thank you for filling out an application and helping the sponsor provide nutritious meals and snacks that can help your child grow stronger and healthier.

Sincerely,

MSTPR. Jonathan Biven Camp Director / Commander Trooper Island Camp September 13, 2019
Name Title Date

If you have any questions about the Summer Food Service Program application, please call (270) 433-5422

Report any of this income that you received last month:

Gross Income from Work
Wages/salaries/tips
Strike benefits
Unemployment compensation
Workers' compensation
Net income from self-owned Business or Farm

Welfare/Child Support/Alimony
Public assistance payments
Welfare payments
Alimony payments
Child support payments

Pensions/Retirement/Social Security
Pensions
Retirement income
Social Security
Veteran payments
Supplemental security income

Other Income
Earnings from second job
Disability benefits
Interest/dividends
Cash withdraw from savings
Income from estates/trusts/investments
Regular contributions from person not Living in the household
Royalties/annuities/rental income
Any other monies that may be available to Pay for child's meals.

Barren River
DISTRICT HEALTH DEPARTMENT
Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Simpson, and Warren Counties

Barren River District Health Department Privacy Notice
Effective September 23, 2013

PLEASE READ CAREFULLY:

This privacy is required by the ***Health Insurance Portability and Accountability Act (HIPAA)*** of 1996.

The privacy of your medical information is very important to us at the **Barren River District Health Department**. We need this record to provide you with quality and efficient health care.

This notice provides you with information on how your medical information may be used and disclosed and how you can access medical information. This notice also describes your rights in accessing and amending your medical health information.

Protected Health Information (PHI) is the information, either verbal or recorded, that is created or received by the Barren River District Health Department and its eight county centers. This is information that is used to provide services to you or information that allows us to receive reimbursement for services provided to you or anyone you may represent, such as dependents.
We will use and disclose protected health information in the following ways:

WITHOUT your signed authorization:

- **Treatment/Services:** This includes the provision or management of healthcare and related services. ***We will not disclose psychotherapy notes, PHI for marketing purposes, and disclosures that constitute a sale of PHI without your authorization.***
- **Payment:** We will request payment from any payer source you list as a provider of reimbursement.
- **Healthcare Operations:** We may obtain services from other health care providers (business associates) to provide further evaluation, in order to meet state-mandated protocols or legal services. We will share your PHI with our business associates as necessary. All of our business associates have agreed to all required confidentiality agreements to protect your information.
- **Public Health Law:** We will, as required by law, disclose your PHI to state and federal public health agencies as mandated, including the reporting of disease, injury, abuse and neglect and public health surveillance. This information will be given ONLY to authorized staff at the state and federal level of government.
- **Other:** We will disclose your PHI in the following situations without your signature: Food & Drug Administration regulations, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity & national security and Workers' compensation.

Unless you object, we may disclose your PHI to notify a family member or other personal representative in an emergency situation.
We will contact you about *appointment reminders* and other health-related services that we may offer at the Barren River District Health Department and its local centers.
Other disclosures will be made only with your consent.

YOUR RIGHTS:

- You have the right to request restricted access to all or part of your PHI in writing to our district office or local county office in the format in which it is maintained.
- You must authorize the disclosure of psychotherapy notes, PHI or marketing purposes, and disclosures that constitute a sale of PHI.
- You have the right to restrict certain disclosures of PHI to a health plan where you have paid out of pocket in full for the health care item or service.
- You have the right to receive copies of your PHI. This request must be made in writing.
- You have the right to request that your medical record be amended to correct what you feel to be incorrect information. You may file a statement of disagreement with the contents of your medical record. Your statement will be reviewed by our Privacy Officer. If your amendment is denied, this denial will be attached to your medical record, along with your statement, and be disclosed with all further PHI releases.
- You have the right to complain if you believe we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. For further information on filing a complaint, contact the Privacy Officer at the Barren River District Health Department at the address or phone number listed below.
- You have the right to be notified following a breach of unsecured PHI.

Please contact the Barren River District Health Department's Privacy Officer if you have questions about this notice or if you believe your privacy rights have been violated.

Attn: Privacy Officer
Barren River District Health Department
P.O. Box 1157
Bowling Green, KY 42101
(270)781-8039

Barren River
DISTRICT HEALTH DEPARTMENT
Barren, Butler, Edmonson, Hart, Logan,
Metcalfe, Simpson, and Warren Counties

CONSENT FOR DENTAL TREATMENT

CHILD'S NAME _____ BIRTHDATE:_____ RACE:_____ HISPANIC ▭Y ▭N

ADDRESS: _____ ▭MALE ▭FEMALE

SCHOOL THIS CHILD ATTENDED LAST YEAR_____

CHILD'S SOCIAL SECURITY #:_____ HOME PHONE #:_____ WORK/CELL#:_____

EMERGENCY CONTACT NAME: _____ PHONE#_____
Who does the child live with? _____

KY MEDICAID #(if applicable):_____
STUDENT'S DOCTOR: _____ DOCTOR'S PHONE #:_____
STUDENT'S DENTIST: _____

WHEN WAS HIS/HER LAST DENTAL CHECK-UP? _____ DOES YOUR CHILD REGULARLY SEE A DENTIST? _____

Has your child ever had any of the following:
Y / N – Any Operations
Y / N – Bleeding Problems
Y / N – Convulsions / Epilepsy
Y / N – Diabetes
Y / N – Hearing Impairment
Y / N – Heart Murmur
Y / N – Heart Problem of Any Kind
Y / N – Hemophilia
Y / N – HIV+ / AIDS
Y / N – Hyperactive
Y / N – Rheumatic Fever / Scarlet Fever
Other-

DOES YOUR CHILD REQUIRE PRE-MEDICATION(antibiotics)? Please circle YES NO

Please circle one if applicable Pregnant Taking oral contraceptives

ALLERGIES/ASTHMA (food, insects, medication, other)_____

CURRENT MEDICATIONS: _____

CONSENT FOR HEALTH SERVICES AND ASSIGNMENT OF BENEFITS (Expires 1 year from date signed)

I certify that my answers are correct and complete to the best of my knowledge. Of my own free will, I consent to care which may include dental assessments/exams, dental cleanings, x-rays, fluoride treatments, amalgam(silver)and/or composite(white) fillings, minor extractions(tooth or teeth pulled) and dental sealants by a Dentist and/or a Public Health Registered Dental Hygienist affiliated with the Barren River District Health Department. The dentist will be present to perform the exam, fillings, and extractions but may or may not be present during the cleaning, fluoride, x-rays and sealant appointment. If your child has cavities or needs an extraction of a tooth, they may be referred out to a participating dentist with BRDHD. I understand that no guarantees are being made as to the effect of any exam or treatment on my child. I understand that my child may be tested for HIV infection, Hepatitis B, or other diseases carried by the blood or body fluids if such tests are needed only in the event that a healthcare worker is exposed to his/her blood, body fluids or tissue. I authorize the dental clinic to release dental information about my child, as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to his/her primary care provider and to share pertinent dental information (history of allergies or significant dental history) with school staff who may need to provide care to my child in an emergency. I understand that the sharing of this information is on a need to know basis only. I request that payment of authorized medical insurance benefits be made to Barren River District Health Department on my behalf, for services my child receives. I also authorize the local health department to release dental information about my child to Medicaid/KCHIP to determine payment for services. I also understand by signing this consent, I acknowledge that I have received a copy of the Barren River District Health Department's Privacy Notice. I have read the above and I understand the items above as they apply to me. Signature below indicates I do consent, authorize and declare as stated above. This permission can be revoked at any time.

_____ _____ _____
(Signature of Parent/Guardian) (Printed Name of Parent/Guardian) (Date Signed)