



SKOKIE 73.5

Elizabeth Meyer School • John Middleton Elementary School • Oliver McCracken Middle School

Student Health Services

Katie Orleans, R.N.
Kim Durband, R.N.
Marryann Warda, R.N.

December 20, 2023

Dear Families,

We are writing to inform you of an opportunity for your student to receive preventative dental services at school.

We are excited to announce our continued partnership with Miles of Smiles, Ltd who will operate school-located dental exams in our district this year. **The dental exams will be provided during the school day.**

Planned dates and locations:

March 8, 2024 Middleton
March 15, 2024 Meyer
March 20, 2024 McCracken

All students are eligible, and there is no out-of-pocket cost for families or the school. **If your child is in grade K, 2, or 6 this exam fulfills the Illinois requirement for a dental health examination.**

Participation in this health service is voluntary. Complete the attached consent form as soon as possible if you would like your student to receive this service. Return the completed consent to the building nurse.

Only students with a completed consent form will participate.

Feel free to contact us with any questions.

Sincerely,

Katie Orleans, RN 847-676-8360
Kim Durband, RN 847-676-8020
Marryann Warda, RN 847-676-8235

ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

Rev 06/17

PLEASE PRINT IN INK

DENTAL EXAM

Services Rendered By:



MUST BE RETURNED TOMORROW (ONLY IF YOU WANT THESE SERVICES)



Miles of Smiles, Ltd.

2424 N 8th St

Pekin, IL 61554-1547

309-382-6404

NAME OF SCHOOL: _____

TEACHER: _____

GRADE: _____

COUNTY: _____

DO YOU HAVE A DENTIST? YES / NO

DENTIST'S NAME: _____

EXAM DATE: _____

PROVIDE THE FOLLOWING INFORMATION ONLY IF YOU WANT THESE DENTAL SERVICES

to be rendered by Miles of Smiles, Ltd at school.

Dear Parent or Guardian,

Miles of Smiles, Ltd. and The Illinois Department of Healthcare and Family Services have arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, hygienists, and assistants will come to your child's school with portable equipment. In order for your child to receive these services, you must **PROVIDE ALL THE INFORMATION REQUESTED BELOW AND SIGN IN THE AREA INDICATED.**

YOUR CHILD'S LEGAL NAME: _____

BIRTH DATE: ____/____/____

ADDRESS: _____

GENDER: M / F

CITY/ZIP: _____

HOME PHONE: _____

DOES YOUR CHILD QUALIFY FOR FREE OR REDUCED MEALS: YES / NO

IS YOUR CHILD ENROLLED IN THE 'Medicaid/All Kids' PROGRAM: YES / NO

MCO COMPANY NAME (if not listed): _____

MCO COMPANY NAME (circle one): Aetna, BCBS, Cigna, CommunityCare, CountyCare, Family Health Network, Harmony, Humana, IlliniCare, Meridian, Molina

IF YES, INCLUDE YOUR CHILD'S RECIPIENT ID NUMBER: _____

Medicaid/All Kids will be billed

(9 DIGIT ID NUMBER ON BACK OF MEDI-PLAN CARD)

IS YOUR CHILD COVERED BY PRIVATE DENTAL INSURANCE: YES / NO

(if incomplete, only grades K, 2nd, & 6th may be eligible for an exam)

IF YES, please fill out ALL the insurance information below: **(DENTAL INSURANCE COMPANY WILL BE BILLED)**

Name of Dental Insurance Company: _____

Dental Insurance Company Address: _____

Member's (employee) ID or SS #: _____

Dental Insurance plan or group number: _____

Member's name: _____

Member's Birth Date: _____

Member's Address (if different than child's): _____

Member's Phone Number (if different than child's): _____

Employer: _____

Has your child had any history of, or conditions related to, any of the following: (Please circle)							
Anemia:	YES / NO	Chronic Sinusitis:	YES / NO	Growth problems:	YES / NO	Seizures:	YES / NO
Asthma:	YES / NO	Diabetes:	YES / NO	Hearing:	YES / NO	Thyroid:	YES / NO
Bleeding disorders:	YES / NO	Ear aches:	YES / NO	Heart Disease:	YES / NO	Tobacco / drug use:	YES / NO
Cancer:	YES / NO	Epilepsy:	YES / NO	Latex allergy**:	YES / NO	Allergies:	
Cerebral Palsy:	YES / NO	Fainting:	YES / NO	Pregnancy (teens):	YES / NO	Other:	
Is your child taking any prescription and/or over the counter medications at this time?					YES / NO		
If yes, please list:							
Does your child have any known heart condition? YES / NO DESCRIBE:							
Does your child have any artificial joints: YES / NO IF YES, WHEN & WHAT JOINT:							
Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatment? YES / NO							
IF YES, WHAT:							

IMPORTANT: PARENT/GUARDIAN SIGNATURE REQUIRED (ONLY IF YOU WANT THESE SERVICES)

I am a custodial parent or legal guardian of the minor child named above. I **authorize and consent** to this child receiving the dental treatment described, and allow the school nurse/ school representative and dental provider access to child's dental record.

This will also give permission for the Illinois Department of Public Health to provide Quality Assurance Audits by evaluation of your child's sealants that were placed at the school. Upon determination, this permission will also allow for the sealants to be replaced by the provider if indicated.

To the extent permitted by law, I consent to the use and disclosure of the minor child's protected health information to carry out payment activities in connection with this claim. I hereby **authorize and direct payment** of the dental benefits directly to Miles of Smiles, Ltd.

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

IF YOU HAVE A DENTIST, SEEK DENTAL CARE THERE!

DDS INITIALS _____

RDH INITIALS _____



Miles of Smiles, Ltd.



ATTENTION PARENTS!!!!!!

Miles of Smiles, Ltd. is providing preventive dental services at your school to eligible children in **all grades**.

Services may include exam, cleaning, fluoride varnish, and sealants if needed.

This also satisfies the dental requirement mandated by the State of Illinois for school children (Kindergarten, 2nd, 6th, and 9th).

Please sign up your child today to receive this wonderful service.

There is ***no cost*** to the family or school.

After the services are performed, the following entities will be billed where applicable: IL Medicaid program, public/private grants, or private dental insurance. Miles of Smiles, Ltd. will accept any reimbursement as the final payment (even if the claim is denied). The families and the schools are never billed for any co-payments, deductibles, or balances.

There is never any cost to the school or to the families.

***If you see a dentist regularly,
please continue for routine exams and x-rays!***

All Kids online application & forms:
<https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/application.aspx>
All Kids Hotline: 1-866-ALL-KIDS (1-866-255-5437)

2424 N. 8TH St., Pekin, IL 61554 * Office: 309-382-6404 * Fax: 309-382-6405