Documentation of Self-Sufficient Minor Status

California

For the purposes of obtaining medical, dental or surgical diagnosis or treatment, pursuant to California Family Code §6922, I hereby certify that the following is true:

1. I am 15-years-old or older, and was born on _____ (Date), at _____ (Location)

2. I am living separate and apart from my parents or legal guardian.

_____ _____
(Residence) (Phone)

_____ _____
(Residence of parents/guardians) (Phone)

3. I am managing my own financial affairs.

_____
(Name and Address of Employer)

_____
(Other Source(s) of Income)

_____
(Location of Bank Account)

4. I understand that, under the law, I will be financially responsible for my medical, dental, or surgical care and treatment.

_____ _____
(Signed) (Date)

Preschool Child Dental Exam Form

Child's Name	Date of Birth:
Preschool Classroom site:	Gender: ☐ Male ☐ Female

Date of Dental Exam: _____

☐ Cleaning ☐ Fluoride Treatment

Treatment needs: (check only one based on exam results)

☐ No obvious problems: The child's hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ Requires Dental Care: Tooth decay or gum infection is suspected. *

☐ Requires Urgent Dental Care: Obvious tooth decay is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain. *

*Follow up Treatment:

☐ Treatment is scheduled for _____

☐ Child was referred to _____ for treatment

Provider Name (please print): _____ Provider Business Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider: _____ Date: _____

Please return completed form to NICAO Head Start, 1190 Briarstone Drive, Mason City IA 50401

Caregiver's Authorization Affidavit

California

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1-4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5-8 is additionally required to authorize any other medical care. Print clearly.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor: _____
2. Minor's birth date: _____
3. My name (adult giving authorization): _____
4. My home address: _____
5. ☐ I am a grandparent, aunt, uncle, or other qualified relative of the minor (see back of this form for a definition of "qualified relative").
6. Check one or both (for example, if one parent was advised and the other cannot be located):
   - ☐ I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.
   - ☐ I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.
7. My date of birth: _____
8. My California's driver's license or identification card number: _____

WARNING: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: _____ Signed: _____

Notices:

1. This declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the caregiver has legal custody of the minor.
2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.
3. This affidavit is not valid for more than one year after the date on which it is executed.

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Additional Information

TO CAREGIVERS

1. "Qualified relative," for purposes of item 5, means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great," or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

2. The law may require you, if you are not a relative or a currently licensed foster parent, to obtain a foster home license in order to care for a minor. If you have any questions, please contact your local department of social services.

3. If the minor stops living with you, you are required to notify any school, health care provider, or health care service plan to which you have given this affidavit.

4. If you do not have the information requested in item 8 (California driver's license or I.D.), provide another form of identification such as your social security number or Medi-Cal number.

TO HEALTH CARE PROVIDERS AND HEALTH CARE SERVICE PLANS

1. No person who acts in good faith reliance upon a caregiver's authorization affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit, is subject to criminal liability or to civil liability to any person, or is subject to professional disciplinary action, for such reliance if the applicable portions of the form are completed.

2. This affidavit does not confer dependency for health care coverage purposes.

Authorization for the Release of Dental Records

California

I hereby authorize _____, DDS to release the information in the dental record of _____ (patient's name) to

_____
(name of dentist, physician, clinic, or patient's representative)

_____
(address)

_____

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

_____

_____

[**Optional:** I understand and agree to pay a reasonable charge to cover the cost of the transfer, as allowed in Health and Safety Code §§123100 *et seq.* and Evidence Code §1158.]

This authorization is effective now and will remain in effect until _____ (date). I understand that I may receive a copy of this authorization.

_____ _____
Signature Date

If not signed by the patient please indicate relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient

NOTE: This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.

CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request.

To be valid, an authorization must be clearly separate from other language on a page and executed by a signature which serves no purpose other than to execute the authorization. It can either be handwritten by the person who signs it or in typeface no smaller than 8 point **(this is 8 point)**.

COPY TO BE PLACED IN PATIENT'S CHART

[8/2003]

Authorization for Agent to Consent to Dental Treatment of a Minor

California

I hereby authorize _____ (an adult into whose care the minor(s) has been entrusted) to consent to any X-ray examination, anesthetic, or dental diagnosis or treatment of _____ deemed advisable by a dentist or hygienist and provided by that dentist or hygienist or under that dentist's or hygienist's supervision regardless of where that treatment is provided.

This authorization is made under California Family Code §6910.

Signed: _____ Dated: _____

Please specify relationship to minor:

- ☐ Parent with legal custody
- ☐ Guardian with legal custody

FEN-PHEN ALERT!

TO ALL PATIENTS WHO HAVE TAKEN FEN-PHEN OR REDUX:

Millions of people have taken Fen-phen or Redux medications. According to the U.S. Food and Drug Administration, as many as 32 percent of the diet-drug users may have developed cardiac valve damage, placing them at risk for bacteremia-induced infective endocarditis. Endocarditis is an inflammation that occurs when bacteria carried in the blood lodges on the damaged valves or in the lining of the heart. Some dental procedures can allow the entrance of bacteria in the bloodstream. Simple dental procedures like cleaning, placing orthodontic bands and scaling as well as more invasive procedures like root canals, tooth extractions and dental implants may require antibiotic treatment before the dental procedure.

*The **Department of Health and Human Services** issued the following recommendations:*

> *1. All people exposed to fenfluramine or dexfenfluramine for any period of time, alone or in combination with other agents, should undergo a medical history and cardiovascular examination by their physician to determine the presence or absence of cardiopulmonary signs and symptoms. (Emphasis added.)*
>
> *2. An echocardiographic evaluation should be performed on such exposed people who exhibit cardiopulmonary signs (including a new murmur) or symptoms suggestive of valvular disease (e.g. dyspnea).*
>
> *3. Practitioners (physicians) should strongly consider performing echocardiography on all people - regardless of whether they have cardiopulmonary signs or symptoms - who have been exposed to fenfluramine or dexfenfluramine for any period of time, either alone or in combination with other agents, before the patient undergoes any invasive procedure for which antimicrobial endocarditis prophylaxis is recommended by the 1997 American Heart Association (AHA) guidelines. Any echocardiographic findings that meet the 1997 guidelines for prophylaxis - regardless of whether they are attributable to possible fenfluramine or dexfenfluramine use - should be recognized as indications for antibiotic prophylaxis. For emergency procedures for which cardiac evaluation cannot be performed, empiric antibiotic prophylaxis should be administered according to the 1997 AHA guidelines. (Emphasis added.)*

This warning affects dental care. Any dental procedure that could cause significant bleeding may require you to take pre-treatment antibiotics depending on the cardiac evaluation results. Current guidelines from the American Heart Association preclude preventive antibiotic treatment without legitimate medical cause. The new guidelines are to aid patients in diminishing the adverse effects of preventive antibiotic treatment, which include development of resistance to antibiotics.

Before your next dental appointment, please advise your dentist if you have taken Fen-phen or Redux.