

**PUBLIC HEALTH NURSING AGENCY
WARREN COUNTY HEALTH DEPARTMENT
162 E. WASHINGTON AVENUE
WASHINGTON, NJ 07882
TEL: (908) 689-6000**



PETER SUMMERS
Health Officer

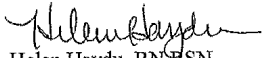
JUDITH A. LEONE, RN, BSN
Public Health Nurse Supervisor
Division Head

January 30, 2012

The Zufall Health Center has organized a free Pediatric Dental Clinic for the children of Warren County. This clinic will be held on February 29, 2012 starting at 10:00 a.m. and ending at 2:00 p.m. The location is 116 E. Washington Ave., Washington, NJ (United Methodist Church) lot. The clinic will be held in the Highlands Health Van in the side parking lot of the Methodist Church.

Please advise parents to call Warren County Public Health Nursing Agency for an appointment. Clients will not be seen without making an appointment with the WCPHNA first. Please call 908-689-6000 ext. 260 or 261 to sign up for this free dental service. Parents must fill out the dental "General and Health Information" form attached (English or Spanish). Appointments must be canceled by calling WCPHNA so we may schedule other clients for those times.

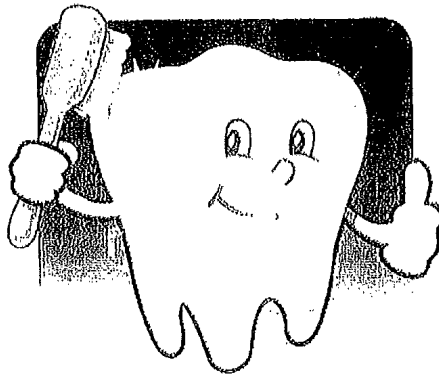
Thank you,


Helen Haydu, RN BSN
Assistant Nursing Supervisor



ZUFALL HEALTH CENTER

ATTENTION PARENTS



Register your child for a dental check-up
Fill out the permission slip today

Preventive services include:

- Dental exams/screenings
- Cleanings and free toothbrushes
- Fluoride and Fluoride Varnish
- Dental "report card" provided with each visit
- Uninsured children receive care at no charge
- All children are eligible

Registre su hijo para un chequeo dental
Complete la forma hoy

Estos servicios preventivos:

- Examen dental
- Limpieza dental y cepillo dental gratis
- Tratamiento de fluoruro
- Usted recibirá una tarjeta de reporte en cada visita
- Niños sin seguro reciben atención gratuita
- todos los niños son elegibles

Zufall Health Center • 2-4 Alno Avenue • Morristown, NJ 07960 • 973.267.0002 • zufallhealth.org



ZUFALL HEALTH CENTER
DENTAL SCREENING PROGRAM

General and Health Information

PLEASE PRINT CLEARLY IN INK

School: _____
 Teacher: _____ Grade: _____ Room#: _____
 Child's Legal Name (First Middle Last): _____
 Child's Date of Birth (M/D/Y): _____ Child's Sex: M F Last Dental Visit: _____
 Race: Asian Black/African American White
 More than one race Native Hawaiian
 Other Pacific Islander American Indian/Alaska Native
 Ethnicity: Hispanic Non-Hispanic
 Parent / Guardian Name: _____ Phone: () _____
 Relationship to Child: _____ E-Mail: _____
 Address: _____ City/Zip: _____

DENTAL QUESTIONNAIRE

Please use the area below to provide details about medical problems, allergies, to list any current medications, or provide any other relevant health information.

1. Have you ever been told by a physician or dentist that your child needs to take an antibiotic before dental treatment? No Yes _____
2. Does your child take any medications? No Yes _____
3. Does your child have any allergies? No Yes _____
4. Has your child ever had any health problems? No Yes _____
5. Is your child allergic to any medication? No Yes _____
6. Has your child ever had rheumatic fever or heart disease? No Yes _____
7. Is your child allergic to latex or latex products? No Yes _____
8. Has your child been a patient in a hospital? No Yes _____
9. Is a physician treating your child? No Yes _____

MEDICAID PAYMENT STATUS		EXP. DATE	PLAN	PREFEX-POLICY NO. SUFFIX
1. Medicaid (Title 19)				
2. Private Insurance	Name	Group #	Identification #	Address
3. Uninsured Attestation	I attest that my child has no insurance. Signature: _____			

SIGNATURE REQUIRED

I, the parent or legal guardian of the minor child named above, consent and authorize the Zufall Health Center doctors and staff to provide preventive dental services to my child including screenings, cleanings and fluoride, during the school year. I also allow the school nurse/school representatives and/or a dentist of my choosing to obtain the child's dental record. I have had an opportunity to ask any questions about services my child may receive. I acknowledge receiving a copy of the Zufall Health Center Notice of Privacy Practices.

X. Sign _____ Date: _____

