No Cost to Parent **Preventive Oral Health Program** Teacher: _____

_____ School

☐ **Yes** I approve of my child's participation in this program.
☐ **No** I do not approve of my child's participation in this program.

Name of Child _____ **Sex** ☐ M ☐ F
Street Address _____ **Zip Code** _____
SSN _____ **Date of Birth** _____

Race ☐ American Indian/Alaskan Native ☐ Asian
☐ Black/African American ☐Native Hawaiian ☐ Other _____
☐ Hispanic ☐ White

Check which applies: ☐ Staywell ☐ Prestige ☐ Argus ☐ Private Insurance ☐ Other ☐ None

Child Medicaid # _____ **ID #** _____

Child on Free or Reduced Lunch Program? ☐ Yes ☐ No

Child's Parent/Guardian's Name: _____ **Relationship:** _____
Daytime Telephone: _____

****Anyone other than a natural parent giving consent for treatment must provide legal documentation of guardianship. ****

Child's Health History

Please check **Yes** or **NO** for each of the following regarding your child's health: (check all that apply)

YES	NO	
☐	☐	Does your child have a history of a heart murmur?
☐	☐	Does your child have Asthma? Asthma medicine: _____
☐	☐	Does your child need antibiotics (e.g. amoxicillin) before dental care?
☐	☐	Is your child allergic to anything? Please list:
		_____
☐	☐	Does your child have any health problem(s)? If none please write N/A.
		_____
☐	☐	Has your child ever been hospitalized? Why? _____
☐	☐	Does your child take any medications? List: _____
☐	☐	Has your child ever had a negative reaction to dental treatment? Explain: _____
		_____

Please add any comment or additional information you feel is important for us to know:

_____

I certify I have **READ** and **UNDERSTAND** the above questions and have answered them to the best of my knowledge. This dental care may include: dental screening/assessment, prophy (dental cleaning), oral hygiene instructions, sealants and fluoride. I understand that my child is not being provided other dental care that she/he may need. These services are not a substitute for a comprehensive dental examination. I authorize the dental providers to receive payment from any insurance or third party payer that covers the services provided to this patient. Services will be provided to all children at no cost to the patient.

Parent signature: _____ Date: _____

Dentist signature: _____