School Dental Consent Form

☐ **YES**, I want my child to participate in the school dental program. (Please fill out the entire form as accurately as possible)

☐ **NO**, I *do not* want my child to participate in the school program. (Only fill out child's name and sign at bottom or form)

Name of Child: *(first)*_____ *(last)* _____

Date of Birth_____/_____/_____ ☐ **Male** ☐ **Female** **Best Phone # to reach family:** _____

Address_____ **City**_____ **Zip**_____

School_____ **Teacher** _____ **Grade** _____ **Family Size:** _____

Ethnicity (Please Check one)	**Race (Check all that applies):**
☐ Not Hispanic or Latino ☐Hispanic	☐ White ☐ Black/African American ☐Asian ☐American Indian/Alaskan Native ☐Pacific Islander

Brief Health History

1. Is your child currently under a physician's care? ☐ Yes ☐ No
2. Is your child currently taking any medications? ☐ Yes ☐ No
3. Has your child ever had any allergic reactions to dyes, foods or medications? ☐ Yes ☐ No
   Please explain any **YES** answers:_____
4. Who is your child's doctor? Name:_____ County of provider: _____
5. Can your child see this doctor for check-ups and sickness? ☐ Yes ☐ No Date of last visit: _____
6. Does your child have medical insurance? ☐ T19/Medicaid ☐ Self ☐ Private medical insurance ☐ *hawk-i* ☐ Other
7. Do you have a regular family dentist? ☐ Yes ☐ No Name: _____ County of Provider:_____
8. My child's most recent dental visit was with the last: ☐ 6 months ☐ 12 months ☐ 3 years ☐ 5 years ☐ Never seen a dentist
9. How do you pay for your child's dental care? ☐ T19/Medicaid ☐ Self ☐ Private dental insurance ☐ *hawk-i* ☐ Other
10. If you have private dental insurance were the sealants covered? ☐ Yes ☐ No
11. List any problems now or recently with your child's teeth._____
12. Do you or anyone in the home have cavities now? ☐ Yes ☐ No
13. How many times does your child eat snack foods, or sugary, sticky foods or drinks each day? _____
14. Does your child carry something around to drink (other than water) at home? ☐ Yes ☐ No
15. Does your child drink fluoridated water, take fluoride supplements or use toothpaste with fluoride in it? ☐ Yes ☐ No
16. Does your child brush at least 2 times a day? ☐ Yes ☐ No
17. Does your child floss daily? ☐ Yes ☐ No
18. Would you like information mailed to you about the *hawk-i* insurance program? ☐ Yes ☐ No

- I understand that these services are provided under the Iowa Department of Public Health (IDPH), Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of Iowa Department of Public Health.
- I understand that the information from these records may be shared with IDPH (Bureaus of Family Health or Oral & Health Delivery Systems) Iowa Department of Human Services (DHS), or designee.
- I understand that services received do not take the place of regular dental checkups at a dental office.
- I understand that this consent is valid for one year upon the date of signature unless withdrawn in writing by the parent or guardian.

Parent/Guardian Signature **Print Name** **Date**

I voluntarily authorize Washington County Public Health to release, obtain, or exchange information with the following: dentists. This release does *not* authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health, and/or AIDs-related information.

Parent/Guardian Signature **Date**