Seal a Smile *School Based Oral Health Program*

A project of Whitney M. Young Jr. Health Services and Healthy Capital District

Consent Form

Dear Parents/Guardians, for us to provide services to your child you must complete this consent form.

School: _____ Teacher: _____ Grade: _____

Child's Name: _____ DOB: _____ Gender M F

Parent Name: _____

Home address: _____ City: _____ Zip Code: _____

Phone: (H) _____ (W) _____ (Cell) _____

Emergency contact person:
Name: _____ Relationship (to child): _____

Phone: (H) _____ (Cell): _____

☐ **No,** I do not want my child to participate in the program at this time.
Signature of Parent or Guardian _____ Date: _____

☐ **Yes,** I want my child to receive dental education, screening, dental cleaning, fluoride treatment, sealants and a parent report.

☐ **Yes,** I want a copy of my child's Student Oral Health Report to be given to the school nurse. It will include the same information as the Dental Health Certificate requested by the school.

Insurance Information

☐ My Child has no health insurance at this time.*

Medicaid, Fidelis, Well Care, CDPHP

ID/CIN # _____

Group # _____

Private Dental Insurance

Company _____

Employee Name & Date of Birth
_____ / /

ID/CIN # _____

Group # _____

**Uninsured children can receive full services if you make arrangements at 462-7049.*

We must have the information on the back completed to serve your child.

Rev. 8.05.21

Seal a Smile *School Based Oral Health Program*

A project of Whitney M. Young Jr. Health Services and Healthy Capital District

***Student's Name**_____**DOB:**_____**

Has your child ever had any of the following? **Please check Yes or No.**

	YES	NO		YES	NO
Heart Disease			Asthma		
Heart Murmurs			Tuberculosis		
Rheumatic Fever			Hemophilia/Bleeding disorder		
Kidney Disease			Seizure disorder		
Anemia			Hearing loss		
Diabetes			Vision problems		
Hepatitis/Liver Disease			Serious injuries		
Autism Spectrum/Asperger's Syndrome			Artificial joints		
Operations/Hospitalizations			Other Health Issues:		
Does your child take medications Please list medications: (Attach list if necessary.)			Allergies: (Please list)		

Does your child (please circle): Drink fluoridated water? Receive daily fluoride supplement/vitamin?

Does your child have a dentist? **Yes / No**

Dentist Name: _____ Address: _____ Phone: _____

Physician name_____Address: _____ Phone: _____

I give permission for my child to participate in the Seal a Smile School Based Dental Program. I also give permission for Seal a Smile staff to exchange information about my child's oral health, health insurance and parent/guardian contact information with my child's dentist, doctor and school district. If my child has health and/or dental insurance, I have provided the Medicaid or CHP number. I also acknowledge receipt that I have received a copy of the HIPAA/Notice of Privacy Practices which can be found on the last two pages of this consent form.

Signature of Parent or Guardian: _____ Date: _____

Print Name of Parent or Guardian: _____ Date: _____

Please send me a survey to provide comments or suggestions to how Seal a Smile School Based Dental Services can best serve your school. **Yes / No**

Please place this form in the envelope provided and return it to school. Thank you!

(Office Use)

Services: Please Circle	*Consent & Health hx reviewed and services provided by:*
Scr FI OHI Pro SL 3-14-19-30-2-15-18-31	_____*RDH,* _____*date*
Scr FI OHI Pro SL 3-14-19-30-2-15-18-31	_____*RDH,* _____*date*
Scr FI OHI Pro SL 3-14-19-30-2-15-18-31	_____*RDH,* _____*date*