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| Permission Form for Dental Treatment at School  |

**Your child can get dental sealants at school**

Dear Parent/Guardian,

A dental health care provider has checked your child’s teeth and determined that he/she can benefit from having permanent molars sealed and/or fluoride applied. This consent is valid for this school year.

 *Please complete the form and* ***return it by:***

|  |
| --- |
| Section 1: Student Information (filled out by parent/guardian) |
| First Name: | Middle Initial:  | Last Name:  | D.O.B: MM-DD-YYYY |
| School Name: | Teacher: | Grade: |  |
| Parent’s/Guardian Name: | Race/Ethnicity: Asian Black/African American Hispanic/Latino Multi-racial Native American Native Hawaiian/Pacific Islander  White Unknown Other (*Please specify*) \_\_\_\_\_\_\_\_\_\_\_\_\_  |

Please complete your child’s health history

Has your child EVER had any of the following? (Please check YES or NO)

**YES NO** **YES NO**

**£** **£** Diabetes **£** **£** Asthma

**£** **£** Bleeding Diseases/Disorders **£** **£** Allergies

**£** **£** Needs antibiotics before dental treatment **£** **£** Heart problems

 **£** **£** Any other serious health problems

 If yes to any of the above, please explain:

 My child is taking these medications:

I understand that the dental program may bill Medi-Cal or my dental insurance to cover costs if my child is currently insured by the Medi-Cal program/private dental insurance.

Does your child have Medi-Cal? **Yes** **£ No** **£** Medi-Cal number

Does your child have Private Dental Insurance? **Yes** **£ No** **£** Insurance Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Primary Subscribers Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Copies of our HIPAA forms (Notice of Privacy Practices) are available in the school office

Please check appropriate boxes & **sign** to receive dental services:

 ** Dental Sealants**   **Clean and Polish Teeth**  **Fluoride Treatment**

I do NOT want my child to receive any dental services.

I also acknowledge that I have been offered or received the Notice of Privacy Practices and HIPAA compliance policy.

**Parent/Guardian Name** (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_**Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature ×\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_