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CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA
PUBLIC HEALTH
FAMILY, MATERNAL AND
CHILD HEALTH PROGRAMS
CHILDREN'S ORAL HEALTH
PROGRAM
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FREE DENTAL SERVICES
Dental Permission Form
(Please sign this form and return it to the teacher immediately)

School_____ **Teacher**_____ **Grade**_____

Dear Parent, Guardian or Caregiver,

The Children's Oral Health Program has selected your child's school to receive **FREE** preventive oral health services for the 2018-2019 school year. With your permission, your child may receive a **Dental Screening**, **Dental Sealants and Fluoride Varnish**. Please Note: Non-flavored hypoallergenic, lip balm may be used before placing sealants, if needed.

Name of child _____ Sex: ☐M ☐F Date of Birth ____/____/____
Month Day Year

Address:_____ City:_____ Zip:_____

Home Phone: _____ Work/Cell Phone: _____

Health History:

1. Has your child ever had any of the following (Please check all that apply):
   ☐ Hepatitis ☐ Rheumatic Fever ☐ Seizures/convulsions ☐ Asthma
   ☐ Diabetes ☐ Tuberculosis ☐ Heart Murmur ☐ ADD/ADHD
   ☐ Other, please list:_____
2. Is your child taking any medications? ☐ No ☐ Yes, please list: _____
3. Does your child have allergies? ☐ No ☐ Yes, please list: _____
4. Has your child had any reaction to any dental materials? ☐ No ☐ Yes, please list: _____
5. When was your child's most recent dental visit?
   ☐ 0-6 months ago ☐ 7-12 months ago ☐ 1-2 years ago ☐ 3-4 years ago ☐ Never seen a dentist
6. What type of health insurance does your child have?
   ☐ CCHP Medi-Cal ☐ Kaiser Medi-Cal ☐ Blue Cross Medi-Cal ☐ I don't know ☐ Uninsured ☐ My child has private/ employer's insurance

☐ **YES, I want my child to receive FREE preventive dental services, as listed above.**

☐ **NO, I do not want my child to receive FREE preventive dental services.**

Parent/Guardian/Caregiver (signature) _____ Date:_____

July 2017