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CONTRA COSTA
PUBLIC HEALTH

FAMILY, MATERNAL AND
CHILD HEALTH PROGRAMS
CHILDREN'S ORAL HEALTH
PROGRAM

597 Center Avenue, Suite 365
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94553

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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):

- | | | | |
|--|--|---|-----------------------------------|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Seizures/convulsions | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> 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?

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> CCHP
Medi-Cal | <input type="checkbox"/> Kaiser
Medi-Cal | <input type="checkbox"/> Blue Cross
Medi-Cal | <input type="checkbox"/> I don't know
<input type="checkbox"/> Uninsured | <input type="checkbox"/> 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

