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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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_