SAMPLE School Dental Program Permission and Medical History Form

Child's Name: _____ _____ Date of Birth: _ _/_ _ /_ _ _ _ ☐ Male ☐ Female
(First) (Last)

Social Security Number __ __ __ -__ __- __ __ __ __ School _____

Grade _____ Room _____ Teacher _____

☐ **YES**, I give permission for my child to participate in the _____program.
Please complete and return this form.

☐ **NO,** I do **NOT** give permission for my child to participate in the _____program.

General Information:

1. What language does *your child* speak best? _____ What language does *parent* speak at home? _____

2. What is *your child's* race?
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ White ☐ Other

Health Information:

1. Does your child see a doctor for regular checkups? ☐ YES ☐ NO

2. Does your child see a dentist for regular checkups? ☐ YES ☐ NO
If yes, name of the dentist_____

3. In general, how would you describe the health of your child's teeth and mouth?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

4. Is your child taking any medication now? ☐ YES ☐ NO
If yes, please list medications. _____

5. Has a dentist or physician ever told you that your child needs to take antibiotics (penicillin) before having dental treatment? ☐ YES ☐ NO

6. Please check any illnesses or conditions your child has EVER had:

☐ ADD/ADHD	☐ Diabetes	☐ Hepatitis	☐ Rheumatic Fever	☐ Convulsions
☐ Anemia	☐ Epilepsy	☐ Heart Murmur	☐ Seizures	☐ Allergies to Medicine
☐ Asthma	☐ Heart Conditions	☐ Kidney/Liver	☐ Tuberculosis	☐ HIV/AIDS

7. Does your child have any other health conditions? ☐ YES ☐ NO
If yes, please list._____

8. Does your child have any allergies? ***If yes***, please check all that apply: ☐ YES ☐ NO
☐ Penicillin ☐ Antibiotics ☐ Colophonium ☐ Aspirin ☐ Foods ☐ Latex ☐ Resins ☐ Other: _____

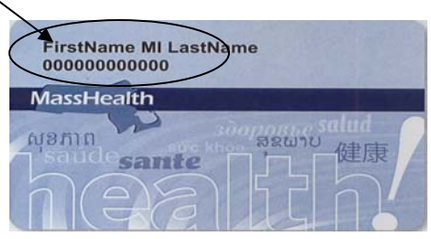
9. Does your child have **DENTAL INSURANCE**? ☐ YES ☐ NO
If no, would you like help getting health or dental insurance for your child? ☐ YES ☐ NO

If your child has dental insurance, please check which one and complete below:
☐ Blue Cross/Shield ☐ Delta Dental ☐ Children's Medical (CMSP) ☐ Mass Health/Medicaid ☐ Other_____

MassHealth

MassHealth RID Number

_____



Delta Dental, CMSP, or Other Dental Insurance

Company_____

Address_____

Subscriber_____

Subscriber ID #_____

Subscriber's Date of Birth _____ /_____/_____

Subscriber's Social Security Number_ _ _/_ _/_ _ _ _

Group/Policy #_____

Employer Name_____

I understand that _____ may use my child's health information for treatment, payment and health care operations. I have been given a copy of their Notice of Privacy Practices. I have read and understand the dental program and services that may be provided to my child. I consent to have my child participate in the program. I authorize the dental program to provide a written summary of the examination-services to an official designated by my child's school. I understand that these services do not substitute for an examination by a dentist and that my child should obtain an examination by a dentist within 90 days, if they have not had one. If needed, this program will provide a list of dentists in my area. I understand that my child may continue to receive dental care from any other provider. If I have dental insurance, I acknowledge that this treatment may affect my future rights and insurance benefits, and I authorize my insurance carrier to be billed for any services provided.

X_____ Date: ___/___/___ **Relationship to Child**: _____
Parent/Guardian Signature

_____	_____	_____	_____
Print Name	**Daytime Phone Number**	**Cell Phone Number**	**Email Address**