School Dental Program

School Year 2016-17

Child's Name:		☐ Male ☐ Female	Age:	Birthdate:
Address:			City:	Zip Code:
Best Phone # to reach family:			Family Size:	
Ethnicity (Please Check one) ☐ Not Hispanic or Latino ☐ Hispanic	Race (Check all that applies): ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Pacific Islander			
School:	Teacher's Name:		Grade:	
Child's Physician:	Child's Dentist:			

☐ **YES**. I want my child to receive FREE dental screenings, sealants & fluoride varnish treatments.

☐ **NO.** I do not want my child to receive dental screenings, sealants & fluoride varnish treatments.

Please answer the following questions:

1. Is your child currently under a physician's care? ☐ Yes ☐ No
2. Is your child currently taking any medications? ☐ Yes ☐ No
3. Has your child ever had any allergic reactions to dyes, foods or medications? ☐ Yes ☐ No
   Please explain any **YES** answers:______________________________
4. Do you have a regular family dentist? ☐ Yes ☐ No
5. If yes, does your child see that dentist at least once a year? ☐ Yes ☐ No
6. Is your child eligible for the free/reduced lunch program at school? ☐ Yes ☐ No
7. My child's most recent dental visit was with the last: ☐ 6 months ☐ 12 months ☐ 3 years ☐ 5 years ☐ never seen a dentist
8. How do you pay for your child's dental care? ☐ Self ☐ T19/Medicaid ☐ Private dental insurance ☐ *hawk-i* ☐ other
9. List any concerns you have about your child's mouth or teeth______________________________
10. I consent to the agency's use of email and texting to send me scheduling and child health services information. ☐ Yes ☐ No

- If wanting a copy of the Notice of Privacy Practices, please visit our website www.washph.com
- I understand that this consent is valid for one (1) year upon the date of signature unless withdrawn in writing by the parent or guardian.
- I understand that services received do not take the place of regular dental checkups at a dental office.
- I understand that these services are provided under the Iowa Department of Public Health (IDPH), Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health, Iowa Medicaid Enterprise, or designee for audit and quality improvement purposes or other legally authorized purposes.

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Parent/Guardian Signature **Print Name** **Date**

I voluntarily authorize Washington County Public Health to release, obtain, or exchange information with your dental provider/school. This release does *not* authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health, and/or AIDs-related information.

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Parent/Guardian Signature **Date**