School Dental Program Consent Form

Please print in ink and return to your child's teacher tomorrow

School Name: _____ Grade: _____ Homeroom: _____

Child's Name: _____ _____ __ __/__ __/__ __ __ __ ☐ Male ☐ Female
(first) (last) (Date of Birth)

Child's Address: _____ _____ _____
(Street) (city) (zip code)

Best Phone Number: __ __ __- __ __ __ - __ __ __ __ Alternative Phone Number: __ __ __- __ __ __ - __ __ __ __

Email Address: _____

General Information:

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

Health Information:

1. Does your child see a dentist for regular checkups? ☐ YES ☐ NO
If yes, name of dentist_____ Date and reason for visit: _____

2. Is your child taking any medication now? ☐ YES ☐ NO
If yes, please list medications_____

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

☐ ADD/ADHD	☐ Diabetes	☐ Hepatitis	☐ Herpes/cold sores	☐ Immune disorders
☐ Blood disorders	☐ Epilepsy	☐ Heart Conditions	☐ Seizures	☐ Kidney/liver disorder
☐ Cancer	☐ Asthma	☐ Tuberculosis	☐ HIV/AIDS	☐ Developmental disability

☐ Other: _____

4. Does your child have any other health conditions or disabilities? ☐ YES ☐ NO
If yes, please list: _____

5. Does your child have any allergies? Please check all that apply: ☐ YES ☐ NO
☐ Penicillin ☐ Antibiotics ☐ Foods ☐ Latex ☐ Resins ☐ Pine Nuts ☐ Other: _____

****Please notify the school if there are any changes in your child's medical history or medications during the school year.**

6. Does your child have **Dental Insurance**? ☐ YES ☐ NO
If your child has dental insurance, please check which one and complete below:
☐ Mass Health/Medicaid ☐ Blue Cross/Shield ☐ Delta Dental ☐ Children's Medical (CMSP) ☐ Other _____

MassHealth Number

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Delta Dental, CMSP or Other Dental Insurance

Insurance Company_____
Address_____
Subscriber Name_____
Subscriber ID #_____
Subscriber's Date of Birth __ __/__ __/__ __ __ __
Subscriber's Social Security Number_ _ _/_ _/_ _ _ _
Group/Policy #_____
Employer Name_____
Employer Address _____

☐ **YES, Full comprehensive dental program – I consent to have my child receive a dental exam, cleaning, fluoride treatment and sealants x-rays, restorations (fillings), and Novocaine as needed.** – I give my permission.

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

I have been given a copy of the HIPPA privacy notice and I understand it is available in the school nurse's office or on line at - http://www.cmohs.net/patients.html. I understand that Commonwealth Mobile Oral Health Services (CMOHS) and CMOHS Dental Providers may use my health information and my child's health information for treatment, payment, program evaluation and health care operations. I understand my child's dental records are confidential to CMOHS. I understand that CMOHS may refer my child to a specialist and speak with my dental insurance company. If I have dental insurance, I authorize my insurance carrier to be billed for any services provided. I understand it is my responsibility to update the dentist of any medical changes. For the full comprehensive program, I authorize the CMOHS dental provider to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read and understand the dental program and I consent to have my child to participate in the dental program.

Parent/Guardian Signature: _____ Date: _____

Print name: _____ Relationship to Child: _____