School Dental Program Consent and Medical History Form

Child's Name: _____ _____Date of Birth: _ _/_ _ /_ _ _ _ ☐ Male ☐ Female
(First) (Last)
Home address_____ Town_____ Phone#_____
School_____ Grade _____ Room ____ Teacher _____

☐ **YES**, I give permission for my child to participate in the North Attleboro Schools Preventive Dental Program
Please complete and return this form.

☐ **NO,** I do **NOT** give permission for my child to participate in the North Attleboro Schools Preventive Dental P

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 and town of the dentist_____
3. In general, how would you describe the health of your child's teeth and mouth? ☐ Excellent ☐ Good ☐ 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 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
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 (pine rosin) ☐ Aspirin ☐ Foods ☐ Latex ☐ Resins ☐ Pine Nuts
   ☐ Other: _____
9. Does your child have **DENTAL INSURANCE**? ☐ YES ☐ NO

If your child has dental insurance, please check and complete all that apply below:

MassHealth

MassHealth RID Number

(Located directly under name on card)

_____

Delta Dental, CMSP, or Other Dental Insurance

Insurance Company_____

Address_____

Subscriber_____

Subscriber ID #_____

Subscriber's Date of Birth _____ /_____/_____

Group/Policy #_____

Employer Name_____

I understand that Cathy Grinham RDH may use my health information for treatment, payment and health care operations. I have been given a copy of the Notice of Privacy Practices. I have read and understand the dental program and services that may be provided to my child, and I consent to have my child participate in the program. I consent to have my child screened in 6 months and 1 year intervals for sealant retention and fluoride treatment. 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. I understand that my child should obtain an examination by a dentist within 90 days, if they have not had one, and if needed, this program will provide a list of dentists in my area. I understand that my child may continue to obtain dental care through any other provider. If I have dental insurance, I acknowledge that this treatment may affect 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 Ph Number** **Cell Ph Number** **Email Address**

(For office Use Only) Reviewed By : _____ **Date** ___/___/____