Revised 2/20/14

Child's last name:		**Child's first name:**	
Date of birth:	**Grade:**	**Age:**	**Male / Female**
Address:		**Phone:**	
City and zip:		**Cell:**	
Dental barriers: cost transportation can't find a dentist language hours location fear unaware of need		**Email:**	

Child's Dentist: **Last visit: 6mo 1yr over 3yr never**	**Child's Medical doctor:** **Last visit:**
Medicaid I.D. Number:	**Child's Race**: (*circle*) American Indian/Asian/Black or African American / Native Hawaiian or Pacific Islander/ White
Child qualifies for Free/Reduced lunch? **Yes No**	**Child's Ethnicity**: *(circle)* Hispanic/ Not Hispanic Country of origin:

___YES, I give permission for my child to receive the dental services being offered which includes a dental screening, dental sealants & fluoride varnish application.

___**NO**, I do not give permission for my child to receive the dental services being offered.

If YES, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Is your child currently under a medical doctor's care?
   Yes No If yes, why? Regular checkups or other: _____

2. Is your child currently taking any medications? Yes No If yes, what? _____

3. My child has allergies to: _____ Allergy to latex? Yes No

4. Have you ever been told your child needs to be on an antibiotic before dental treatment? Yes No

5. Do you have any concerns about your child's mouth or teeth at this time? Yes No
   If yes, what? _____

6. How do you pay for your child's DENTAL care? (*Please circle all that apply*):
   Self Medicaid/Title XIX *hawk-i* Private dental insurance Other_____

7. Is your child up to date with his/her immunizations? Yes No

- I understand that this consent is valid for one (1) year unless withdrawn in writing by the parent or guardian.
- I understand that the services that will be 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, Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information form these records may be shared with the Iowa Department of Public Health (Bureaus of Family Health or Oral & Health Delivery Systems), the Iowa Department of Human Services, or designee.
- I understand pictures may be taken of the children participating.

X_____ _____ _____

PRINTED Parent/Guardian Name **SIGNED Parent/Guardian Name** **Date**

I voluntarily authorize Family Inc. to release, obtain, or exchange information with the following: dentist &/or Council Bluffs School staff. 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.

X_____ _____ _____

PRINTED Parent/Guardian Name **SIGNED Parent/Guardian Name** **Date**