DENTAL EXAM & TREATMENT PERMISSION FORM ****Please return by:_____****

School:_____ Teacher:_____ Grade:_____

Dear Parent or Legal Guardian: The DeWitt-Piatt Health Department has arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, registered dental hygienists and agency staff will come to your child's school with portable equipment to provide these services. In some situations the dentist will examine your child's teeth one day and the hygienist will clean, apply fluoride and seal the teeth on a different day. *In order for your child to receive these services you must provide all the information requested and sign in the area indicated. Thank you!*

Child's Name:_____ **Birthdate**:_____

Address:_____

City:_____ Zip:_____

Phone:_____ Male _____ Female _____ Race: _____

Parent or Legal Guardian's name (please print):_____

Does your child *qualify for free or reduced meals at school*? **Yes or No**

Is your child enrolled in the "All Kids" state insurance program (Medicaid) or one of its Managed Care Companies such as Blue Cross Community, Harmony, IlliniCare, Meridian, or Molina? **Yes or No**

Please list the ID No. listed on the Medicaid or Insurance Card: _____

Medical History:

Has your child ever had a history of, or conditions related to, any of the following items: (please circle those that apply)

ADHD	*Anemia*	*Asthma*	*Autism*	*Bleeding Disorder*	*Cancer*
Chronic Sinusitis	*Diabetes*	*Drug Use*	*Earaches*	*Epilepsy/Seizures*	*Fainting*
Growth Problems	*Hearing*	*Heart*	*Hepatitis*	*HIV/Aids*	*Latex Allergy*
ODD	*Thyroid*	*Tobacco Use*	*Other:* _____		

Is your child taking any prescription or over the counter medications at this time? **Yes or No**

If yes, please list: _____

Does your child have a dentist to see regularly for treatment outside of school? **Yes or No** _____

Has your child suffered from injuries to the mouth, head or teeth? **Yes or No**

Does your child have any (check those that apply):

Retainers _____ Braces _____ Artificial teeth _____ Dry mouth _____ Fears of the dentist _____

Problems with brushing _____ Speech difficulties _____ Fears of loud noises _____

Sensitive teeth or areas in the mouth (please describe) _____

In signing this form, you give permission to treat your child and also verify that you have read the additional form regarding HIPAA. This will also give permission for the Illinois Department of Healthcare and Family Services and the Illinois Department of Public Health to review quality assurance by allowing them to return to the school to re-check your child's sealants within 365 days from the date of service. You also affirm that you are a custodial parent or legal guardian of the minor child named above.

Signature:_____ Date:_____

Parent/Legal Guardian