School Dental Health Program – Consent for Services (Tiers 1 and 2)

Please fill out the information below, sign and return it to your child's school.

Child's First and Last Name: _____ **Date of Birth**: _____

What treatment is provided through my child's 802 Smiles dental program?

Your school's program offers dental screenings and may offer dental cleanings and fluoride varnish (where available).

Do you want your child to have this treatment? There are three choices.

- ○ **YES. I want my child to participate in the School Dental Health Program**. I give permission for my child to receive a dental screening, cleaning, and fluoride varnish (where available).

  I allow the School Dental Health Program to give my child's records to their primary dentist (listed on page 2) and to the Vermont Department of Health. I understand that records will be be used to coordinate treatment and evaluate how well this progam works. I understand that the records will be reviewed by a VT-licensed dentist who supervises the dental hygienist. I understand that treatment by the dental hygienist is limited and does not replace a regular dental exam or treatment by a licensed dentist. I understand that the dental hygienist may refer my child to a dentist or other specialist for additional treatment if the child needs treatment that the dental hygienist cannot provide.

- ○ **YES, I want my child to participate in the School Dental Health Program**. I give permission for my child to receive a dental screening, cleaning, and fluoride varnish (where available).

  I do not allow the School Dental Health Program to give my child's records to their dentist or to the Vermont Department of Health.

- ○ **NO, I do not want my child to participate in the School Dental Health Program.**

  Please tell us why you don't want your child to participate in the program:

  _____

This permission stays in effect until it is ended by the child's parent or legal guardian.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

If you said YES to any questions above, continue to the next page.

Child's dental history:

When was your child's most recent dental visit?

○ Within the past year ○ More than a year ago ○ Never been to the dentist

Who is your child's primary dentist? _____

What type of dental insurance does your child have? No child will be denied service because of insurance coverage.

○ Medicaid/Dr. Dynasaur – Your child's Medicaid ID number: _____
○ Private dental insurance (i.e., Delta Dental) ○ Tricare
○ No Insurance ○ Other _____
○ Don't know

Does your child have any allergies? (i.e., medications, food, latex, etc.) ○ Yes ○ No

If yes, what type? _____

Child's medical history:

Does your child….

Use medicine prescribed by a doctor ○ Yes ○ No

If yes, what kind? _____

Need more medical care, mental health, or educational services than other children the same age? ○ Yes ○ No ○ I don't know

Have trouble doing things most children of the same age can do?
○ Yes ○ No ○ I don't know

Need or get special therapy, such as physical, occupational, or speech therapy? ○ Yes ○ No

Need counseling or treatment for any kind of emotional, developmental, or behavioral problem? ○ Yes ○ No

Optional demographic information

Sex: ○ Male ○ Female ○ Non-Binary

Ethnicity (select one): ○ Hispanic ○ Non-Hispanic ○ Don't know

Race (select all that apply):

○ White ○ Black/African American ○ Asian/Asian American

○ American Indian/Alaska native ○ Native Hawaiian/Pacific Islander

○ I don't know ○ Other

Is there anything else you would like us to know about your child?

_____

_____

_____

Return the completed and signed form to your child's school.