



FREE dental services are available at your child's school.

A licensed, dental health professional will be at your child's school during regular school hours. Your child may receive one or more of the following services: dental evaluation, dental sealants, fluoride treatment, and/or a referral.

Information about your child:



(First)	(Middle)	(Last)	(Sex)	(Race)	(Date of Birth)	(Age)
(Home Phone Number)	(Work or Cell Phone)	(Name of School)	(Grade)	(Teacher)		
(Child's Social Security Number) (SSN)						

**Please complete the following medical information by checking each box "yes" or "no".
 Sign and date this consent form.**

- | | | |
|--|--------------------------|--------------------------|
| <u>Has your child ever had:</u> | YES | NO |
| 1. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Heart problems | <input type="checkbox"/> | <input type="checkbox"/> |

List any medicine your child is taking: _____
 List any allergies your child has: _____
 If your child has heart problems, please explain: _____

Has your child had any other serious illnesses or operations? _____
 Does your child need antibiotics before dental treatment? _____
 Is there anything else we should know about your child? _____

YES **I give consent for my child to participate in the school-based preventive dentistry program and have received a copy of the Health Department's privacy practices. To the best of my knowledge, the medical history questions have been answered correctly.**

 (Signature of Parent or Guardian)

 (Date)

(Print Name of Parent or Guardian)

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