



Children's Dental Health Services provides dental care services including teeth cleanings, oral hygiene instructions, fluoride varnish, sealants, exam and x-rays. Services provided are reserved for children 21 and under, households that qualify for income-based assistance, or on medical assistance. Please complete **ONE FORM PER CHILD.**

STOP Do not fill out this form if your child has private dental insurance or an established dental home STOP

Parent/Guardian Consent Form: (Please print clearly and complete the ENTIRE form)

Child's First Name _____ Middle Name _____ Last Name _____

Child's School _____ Grade _____ Teacher _____
(If applicable)

Date of Birth: ____/____/____ Age: _____ Male Female Email Address _____
Month / Day / Year

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

Race/Ethnicity: Caucasian African American Hispanic Asian/Pacific Islander Native American Other

Yes No Is an interpreter needed? If yes, list language: _____

Who needs an interpreter? Child Parent

Yes No Does your child have any diseases or health problems? If yes, list: _____

Yes No Does your child take any medications? If yes, list: _____

Yes No Does your child have any allergies? If yes, list: _____

Yes No Does your household qualify for income-based assistance (Medical Assistance, SNAP, WIC, etc.)?

Yes No Has your child had a dental cleaning in the last 6 months?
If yes, where? _____ When? _____

Yes No Does your child have dental insurance?
If yes, select the insurance type AND provide their Medicaid ID# or PMI#: _____
 U-Care BluePlus MA South Country Medica DENTAL Insurance through work Self

- I acknowledge I am able to exercise my rights under HIPAA and privacy rules of the Health Insurance Portability Accountability Act of 1996 while being able to request additional information at any time by contact Children's Dental Health Services at 507-529-0436.
- I understand these services are provided by a dental hygienist and are not a substitute for a recommended annual exam provided by a dentist.
- I understand this health and consent form is valid for 12 months effective upon the signing date.
- I have the right to revoke this consent at any time by giving written notice to Children's Dental Health Services.
- I understand this information will only be used for dental clinic information limited to our staff, referring dentist, school and public health staff whose work assignments reasonably require access to this data.
- I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment, and health care operations. I also give Children's Dental Health Services permission to send me appointment reminders via text messages.
- I consent to allow pictures of my child to be taken and possibly used in newspapers, web, or for promotional use of Children's Dental Health Services.
- Please print NO if you do not consent to the photo portion of the form: _____

By signing below I give my consent for my child to participate in Children's Dental Health Services School-Based Dental Program. To the best of my knowledge, the medical history questions have been answered correctly and accurately.

Print name of Parent/Guardian

Signature

Date