East Side Health District

All Kids School-Based Dental Program
Consent Form - Dental Exam
Must be returned tomorrow

Please print in ink:
Name Of School: _____
Teacher: _____ Grade: _____
County: _____

Dear Parent or Guardian,
East Side Health District and the Illinois Department of Healthcare and Family Services have 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, hygienists, and assistants will come to your child's school with portable equipment. In order for your child to receive these services, **you must provide all the information requested below and sign in the area indicated.**

Your Childs Name: _____ Birth Date: ____/____ /____ Gender: **M F**

Address: _____ City/Zip: _____ Home Phone: ( ) _____

Does your child qualify for free or reduced meals: **Yes No**
Number Of Family Members: _____ Income Per Year (optional): _____
Is your child enrolled in the 'All Kids' Program: **Yes No**
If yes, Include your child's recipient ID number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Is your child covered by private dental insurance: **Yes No**
Name of Insurance Company _____
Insurance Telephone Number _____ - _____ Group Number _____
Employer Name _____
Name of Insured _____ Date of Birth _____
Social Security Number of Insured Person _____

Has your child had any history of, or conditions related to, any of the following:

____ Anemia	____ Chronic Sinusitis	____ Growth Problems	____ Seizures	____ Asthma
____ Diabetes	____ Hearing	____ Thyroid	____ Bleeding disorders	____ Ear aches
____ Heart	____ Tobacco/drug use	____ Cancer	____ Epilepsy	____ Latex allergy
____ Fainting	____ Cerebral Palsy	____ Pregnancy (teens)	____ Other	

Is your child taking any prescription and/or over-the-counter medications at this time? **Yes No**
If yes, please list: _____
Does your child have any speech difficulties? **Yes No**
Has your child ever suffered injuries to the mouth, head, or teeth? **Yes No**
What type of water does your child drink? ____ City water ____ Well water ____ Bottled water ____ Filtered water

Important: Parent/guardian signature required
I am a custodial parent or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment described, and allow the school nurse/school representative and dental provider access to the child's dental record.

Signature: _____ Date: _____
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 IDPH, QA Audits to be performed and providers to return to your school to recheck your child's sealants.

Dentist's Initials _____

ACKNOWLEDGEMENT
Receipt of Joint Notice of Privacy Practices

I hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from East Side Health District dated September 17, 2024.

Signed: _____ Date: _____

Check if any of the following apply:

____ Parent or Guardian of minor
____ Power of Attorney for Health Care
____ Guardian with power to make health care decisions
____ Health Care Surrogate
____ Mental Health Treatment Preference Declaration Agent

FOR STAFF USE ONLY:

I attempted to obtain an Acknowledgement of the Receipt of the Notice of Privacy Practices on the behalf of the East Side Health District. East Side Health District representative was unable to obtain the Acknowledgement because:

____ Client refused to sign
____ Other (specify): _____

Staff members' initials: _____ Date: _____

(*Staff: Place Acknowledgement in Patient's medical record*.)