**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: _____

Ethnicity: _____

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 permit IDPH, QA Audits to be performed and providers to return to your school to recheck your child's sealants.

Dentist's Initials B L

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 ☐ Health Care Surrogate

☐ Power of Attorney for Health Care ☐ Mental Health Treatment Preference Declaration Agent

☐ Guardian with power to make health care decisions

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**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*.)

DentaQuest of Illinois, LLC October 3, 2012