Government of the District of Columbia
Department of Health
Community Health Administration

Oral Health Division – School-Based Dental Program

Parental Consent Form

Dear Parent or Guardian,

The DC Department of Health, Oral Health Division and its affiliates-Gordon Dental Associates, Ltd have arranged for preventative dental services for all children in your school. While this program will not take the place of regular dental check-ups, daily brushings, flossing and the use of fluoride, it is an effective way of detecting cavities (tooth decay) and possibly preventing future oral health problems.

There is no charge for participation and a group of District of Columbia licensed dentists/hygienists will provide the Dental Exam/Screening, Dental Cleaning, Prophylaxis, Fluoride Treatment and apply Dental Sealants (as needed) at NO COST to students or their families. In order for your child to receive these services **YOU MUST PROVIDE ALL THE INFORMATION REQUESTED BELOW AND SIGN THE AREA INDICATED.**

Please complete and sign this form so that a dentist or dental hygienist can see your child.

If you would like more information, please call Mr. Justice Armattoe at (202) 442-9365 or Ms. Revenia Miller at 202-724-7667 or the school.

_____ **YES**, I WILL ALLOW my child to participate in the oral health survey and Dental Screening Program
(***Please complete the attached medical questionnaire***)

_____ **NO**, I DO NOT allow my child to participate in the Dental Screening Program

Child's Name (Last, First, MI)				**Birth Date (Month/Day/Year)**
Gender:		**Race/Ethnicity:**	*Black/Non Hispanic* ☐	*White/ Non Hispanic* ☐
Male ☐	*Female* ☐	*Hispanic* ☐	*Asian/Pacific Islander* ☐	*Other* ☐:
Parent or Guardian's Signature				**Date**
Home Telephone Number ( )				**Work Telephone Number** ( )
Teacher's Name				**Grade/Room Number**

Please answer the following questions to help us learn more about the children who participate in the DC Department of Health's School-Based Dental Program.

1. My child's most recent dental visit was within the last: (please check one)
   ___6 months ___12 months ___3 years ___5 years ___Never

2. Is Your child's dental care paid for by:

   ____ Self Paid (out-of-pocket)
   ____ Private Dental Insurance
   ____ Medicaid
   ____ Don't Know

   If Medicaid, please provide the ID number _____

   Name of Medicaid Managed Care Plan _____

   Name of Medicaid Dental provider _____

3. Have you heard of dental sealants? ____Yes ____No

Thank You!
☺

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Name of Student _____ **Male** ___ **Female** ___ **Grade** _____

School _____ **Teacher** _____

To Parents: Please fill out and return this form. This information is used in the school program to promote and to protect the health of students.

I. **Childs history of illness** - Has the child had any of the following? (Please check **YES** or **NO**)

YES	NO		YES	NO	
___	___	Diabetes	___	___	Syphilis
___	___	Anemia	___	___	Hearing Problems
___	___	Blood Disease	___	___	Vision Problems
___	___	Hemophilia	___	___	Hepatitis
___	___	Transfusion	___	___	Heart Murmur
___	___	Heart Disease	___	___	Liver Disease
___	___	Hay Fever	___	___	(Rupture) Hernia
___	___	Chicken Pox	___	___	Skin Problems/ Rashes
___	___	Convulsions	___	___	Thyroid Problems
___	___	Epilepsy	___	___	Rheumatic Fever
___	___	Kidney Problems	___	___	Sickle Cell Anemia
___	___	Asthma	___	___	Venereal Disease
___	___	Tuberculosis (TB)	___	___	HIV (AIDS)

Does this child have any allergies? YES ___ NO____
If yes, please explain: _____

Has this child ever had surgery? YES ___ NO____
If yes, please explain: _____

Any other serious illnesses? YES ___ NO____
If yes, please explain: _____

Has this child ever been hospitalized? YES ___ NO___
If yes, when? (Month/Year) _____
Why? _____

Parent's Signature _____ Date _____

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