# CONSENT FOR DENTAL CARE

**DENTAMED HEALTHCARE** is offering **primary and secondary oral health services** for students at **Washington High School of Information Technology.** Licensed dental providers will come to the school to provide these services at no charge to you and your child. Services provided include: **assessment, sealants if appropriate, cleaning, fluoride treatments, x-rays and tooth brushing instructions with a new toothbrush. If necessary, secondary care which may include x-rays, fillings, stainless steel crowns and simple extractions will be scheduled or provided immediately on our mobile dental clinic depending on availability.** A follow-up letter will be sent home with the child after the primary and secondary care treatments detailing what was done and giving recommendations for the future. All procedures will follow recommendations from the American Dental Association and the Centers for Disease Control and Prevention for school-based dental programs. This permission is **effective for 2 years,** and as part of dental services provided we may replace lost sealants when checked after one year or have sealants applied on teeth that were not sealed this year.

**Child's Last Name:** ______________________ **First Name:** ____________________ **Date of Birth** ______________

**Child's Teacher:** ____________________________________ **Grade:** ________ **Gender:** ☐ Male ☐ Female

☐ **YES, I do want my child to participate in school-based dental program.**

☐ **YES, I give the school permission to share my child's information and Wisconsin Student ID number with the school- based program. I give DentaMed permission to contact me by SMS text messaging regarding my child's treatment.**

☐ **YES, I give DentaMed Healthcare permission (in connection with dental services received) and irrevocably agree and consent to allow photographs and/or information from related interviews to be used as part of the dental record, research, public relations, patient counseling, or other purposes.**

☐ **NO,** I don't want my child to participate in the school-based dental program. (Sign and return to your child's school)

**Reason for not participating:** ________________________________________

**What type of DENTAL insurance does your child have?** *No student will be refused services based on their insurance coverage*

☐ Forward Health/Medicaid/BadgerCare ☐ Private Insurance (i.e. Delta, Cigna) ☐ No Insurance ☐ Other ______________

**Race: (select one)** ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska native ☐ Unknown/not available

**Ethnicity (select one):** ☐ Hispanic ☐ Non-Hispanic

***Please answer the following questions about your child: (Circle one)***

1. Does your child use medicine prescribe by a doctor? YES NO

**If yes, what kind?** ________________________________________

2. Does your child need or use more medical care than other children the same age? YES NO
3. Does your child have trouble doing things most children the same age can do? YES NO
4. Does your child need or get special therapy, such as physical therapy, occupational therapy or speech therapy? YES NO
5. Does your child need counseling or treatment for behavior problems, emotional problems, or delays in walking, talking or activities with other children the same age? YES NO

If you selected "yes" to any of the questions (1-5) above: Has this problem lasted or is expected to last at least12 months?

YES NO

**Does your child have any allergies? (i.e. medications, food, latex, etc.)** YES NO

If yes, what type? ____________

**Has your child been seen by a dentist?** ☐**Yes, within the past 6 months** ☐**Yes, within one year** ☐ **Yes, over one year ago** ☐**Never**

Name of your child's primary dentist: ________________________________________

Is there anything else about your child you would like us to know? ______________________________

***The treatment which your child will receive in this program is not meant to be an alternative to regular dental care. It is still strongly recommended that you seek out a dental home (family dentist) for routine dental care including any follow up care which may be recommended after your child has completed this school based oral health program.**

***Signature of Parent/ Guardian/ Student 18 years or older*** ______________________ ***Date*** ________

***Name*** ______________________ ***Contact Tel*** ____________ ***Parent Email.*** ________________

*Form # 2022-08*

*License #: 32-115, email: info@dentamedhealth.com, Tel: 414-877-0707*

# Medical History

*Student's Last Name: ______________________ *First name: ______________________

*Date of Birth: ______-______-______ Female / Male

For the following medical history questions, please (x) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your child's health. This information is vital to allow us to provide appropriate care for your child.

Does your child have or has ever had any of the following conditions:

| Yes | No | Unsure | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Anemia |
| ☐ | ☐ | ☐ | Asthma |
| ☐ | ☐ | ☐ | Autism |
| ☐ | ☐ | ☐ | ADHD/ADD |
| ☐ | ☐ | ☐ | Birth Defects |
| ☐ | ☐ | ☐ | Bleeding Problems |
| ☐ | ☐ | ☐ | Blood Disorders |
| ☐ | ☐ | ☐ | Cancer |
| ☐ | ☐ | ☐ | Cerebral Palsy |
| ☐ | ☐ | ☐ | Developmental Delay |
| ☐ | ☐ | ☐ | Diabetes |
| ☐ | ☐ | ☐ | Downs Syndrome |
| ☐ | ☐ | ☐ | Emotional Problems |
| ☐ | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | ☐ | Fainting Spells |
| ☐ | ☐ | ☐ | Hepatitis |

| Yes | No | Unsure | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Herpes |
| ☐ | ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | ☐ | HIV/AIDS |
| ☐ | ☐ | ☐ | Hyperactivity |
| ☐ | ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | ☐ | Learning Disabilities |
| ☐ | ☐ | ☐ | Liver Disease |
| ☐ | ☐ | ☐ | Mental Disability |
| ☐ | ☐ | ☐ | Muscular Dystrophy |
| ☐ | ☐ | ☐ | Psychiatric Problems |
| ☐ | ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | ☐ | Seizures |
| ☐ | ☐ | ☐ | Sickle Cell Anemia |
| ☐ | ☐ | ☐ | Skin Disorders |
| ☐ | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | ☐ | Tumors |

| Yes | No | Unsure | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Radiation Treatment |
| ☐ | ☐ | ☐ | Chronic Ear Infections |
| ☐ | ☐ | ☐ | Pregnant (at this time) |
| ☐ | ☐ | ☐ | Sexually Transmitted Diseases |
| ☐ | ☐ | ☐ | Hearing Loss/Impairment |
| ☐ | ☐ | ☐ | Heart Conditions/Murmur |
| ☐ | ☐ | | If yes to heart murmur, is an antibiotic required before dental appointments? |
| ☐ | ☐ | ☐ | Jaundice (not at birth) |
| ☐ | ☐ | ☐ | Delayed Speech Development |
| ☐ | ☐ | ☐ | Allergies: ______________ |

Please explain all "Yes" or "Unsure" responses:

Please list any other problems/conditions your child may have:

## Current Medications List

Is your child taking any prescription medications, over the counter medications, vitamins, natural and/or herbal dietary supplements? ☐ Yes ☐ No If yes, please list medications.

| Medication | Reason for Taking | How Much | How Often |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

To the best of my knowledge, the indicated health history remains current.
I understand that any change in the patient's health or medication requires that an updated form be completed.
I certify that I have read and understand the above.
I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.
I will not hold DentaMed Healthcare responsible for any action taken or not taken because of errors or omissions that I may have made in the completion of this form.

**Parent Signature** **Parent Name** **Date**

**Emergency Contact:**

**Emergency Contact Phone #:**