2018-19 SCHOOL DENTAL SERVICES CONSENT

Your student's school has arranged for dental services to be provided at school during the school day. Services are provided by the Champaign-Urbana Public Health District Children & Teens Dental Clinics.
There is NO COST to you.

Services include dental check-ups, cleanings, fluoride and dental sealants to prevent cavities.

Please complete the consent below for your student to be seen. The dentist will send reports home with your student after each visit. Your student should see a dentist every 6 months.
If you need a dentist or you have any questions, please call:
(217) 531-4279

PRINT & USE AN INK PEN

STUDENT'S NAME _____ BIRTHDATE _____

SCHOOL NAME _____ GRADE _____

_____ FEMALE _____ MALE _____ OTHER

RACE:

_____ AMERICAN INDIAN / ALASKA NATIVE

_____ ASIAN

_____ BLACK / AFRICAN AMERICAN

_____ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER

_____WHITE

_____ UNKNOWN

ETHNICITY:

_____ HISPANIC

_____ NON-HISPANIC

_____ UNKNOWN

PARENT OR LEGAL GUARDIAN:

NAME _____ EMAIL _____

ADDRESS _____ APT#_____ CITY_____ ZIP CODE _____

PHONE NUMBER _____ OTHER PHONE NUMBER _____

INSURANCE:

_____ NONE _____ IL MEDICAID _____BLUE CROSS _____ HARMONY _____ILLINICARE

_____MERIDIAN _____MOLINA _____ OTHER: _____

TURN FORM OVER & COMPLETE THE OTHER SIDE

MEDICAL HISTORY

_____ **NO KNOWN MEDICAL CONDITIONS**

_____ ADD, ADHD OR RELATED

_____ AIDS OR HIV POSITIVE

_____ ASTHMA; *USES INHALER?* ____ *YES* ____ *NO*

_____ BLOOD OR BLEEDING DISORDERS

TYPE: _____

_____ BLOOD PRESSURE PROBLEMS

_____*HIGH* _____*LOW*

_____ CANCER; *TYPE:* _____

_____ DIABETES; *TYPE:* _____

_____ EPILEPSY OR SEIZURES

_____ HEARING IMPAIRED

_____ HEART SURGERY OR HEART DISEASE

TYPE: _____

_____ MENTAL DISABILITY: _____

_____ PHYSICAL DISABILITIES

TYPE: _____

_____ PREGNANT

_____ SICKLE CELL ANEMIA

_____ TUBERCULOSIS

_____ OTHER: _____

_____

MEDICATIONS, SUPPLEMENTS, MULTIVITAMINS

_____ **NONE,** or LIST: _____

ALLERGIES

_____ **NONE,** or LIST: _____

"To the best of my knowledge, the questions on this form have been accurately answered. I understand the providing incorrect information can be dangerous to my student's health, and understand that it is my responsibility to contact the dental provider at (217) 531-4279 if any changes occur in my child's medical status.

By signing this form, I give my permission to the Champaign-Urbana Public Health District (CUPHD) Dental Program to treat my student at school during the 2018-19 school year, and also verify that I understand HIPAA and my Privacy Rights, have received copies if I have requested them. This will also give permission for the Illinois Department of Public Health Quality Assurance Audits to be performed, and permission for my student's school to provide additional contact information for me to CUPHD as needed to discuss dental treatment."

PARENT OR LEGAL GUARDIAN SIGNATURE _____ DATE _____

----------for office use only----------

DENTIST'S SIGNATURE _____ DATE _____

CHART # _____ ELIGIBILITY _____