Community Health Connections

Caring for Kids Dental Program

☐ ***NO, I am not interested in having my child participate. (Please do not continue or return form to school. Please recycle this form.)***

☐ **YES,** I give my permission for my child to participate in the **Caring for Kids Dental Program.**
I understand that my child may receive the following as part of the program: dental exam, dental cleaning, fluoride varnish, sealants (as needed).

☐ YES ☐ NO I give my permission for X-rays to be taken as needed.

☐ YES ☐ NO I give my permission for silver diamine fluoride (SDF) and SMART restorations to be done as needed.

PLEASE PRINT

School:_____ **Grade:**_____**Homeroom Teacher:**_____

Last Name: _____ First Name:_____ Date of Birth:_____

Street Address: _____

City: _____ State: _____ Zip:_____

Parents Name: _____

Parent Email: _____ Parent Cell Phone: _____

What language does your child speak best? _____ What language does parent speak best? _____

Sex of Child: ☐ Female ☐ Male ☐ OTHER

What is your child's race? ☐ American Indian/Alaska Native ☐ Asian Indian ☐ Other Asian ☐ Black/African American
☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Somoan
☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Unreported

What is your child's ethnicity? ☐ Cuban ☐ Mexican,Mexican American/Chicano/a ☐ Puerto Rican
☐ Another Hispanic,Latino/a or Spanish Origin ☐ Not Hispanic,Latino/a or Spanish Origin ☐ Unreported/Refused

What is your child's current housing status? ☐ Own/Rent ☐ Doubled Up ☐ Transitional Housing ☐ Homeless Shelter
☐ Street (Living in a private or public place not usually used for sleeping - examples car, park, abandoned building, bus/train station.)

What is your child's housing status: ☐ Section 8 ☐ Public Housing ☐ Not Public Housing

Health History - please complete entire section.

Is your child taking any medications? ☐ NO ☐ YES (*please list)*_____

_____

Does your child have any allergies? ☐ NO ☐ YES *(please list)*_____

Does your child need to take any antibiotics before having dental treatment? ☐ NO ☐ YES (please see below)

If yes, please tell us the reason for pre-med and which antibiotic your child takes:_____

Has your child ever had an illness or condition? ☐ NO ☐ YES (Please check all that apply)

☐ ADD/ADHD ☐ Anemia ☐ Asthma ☐ Diabetes ☐ Epilepsy/Seizures ☐ Heart Condition ☐ Hepatitis ☐ HIV/AIDS
☐ Kidney/Liver Disease ☐ Rheumatic Fever ☐ TB ☐ Other: _____

Does your child have dental insurance? ☐ NO ☐ YES *(please complete below)*

Dental Insurance Company Name:_____

Subscribers Name: _____ Subscribers Date of Birth: _____

ID#:_____ Group Policy # _____

Employer Name: _____

I understand that Caring for Kids may use my child's information for treatment, payment and healthcare operations. I have been offered a copy of the Notice of Privacy Practices. I have read and understand the dental program and services and I consent to have my child participate in the program. I authorize Caring for Kids to provide a written summary of the services provided to my child and to an official designated by my child's school. I understand that my child may continue to receive services from another provider. If I have dental insurance, I acknowledge that these services may affect my future rights and insurance benefits, and I authorize my insurance carrier to be billed for any services provided.

SIGN HERE X _____ Date: _____ Relationship to Child: _____
Parent/Guardian Signature