CHAMPAIGN-URBANA PUBLIC HEALTH DISTRICT
2010-2011 DENTAL SCREENING CONSENT FORM
Students in Grades: PK, K, 2nd, & 6th

School: ______________________________ Grade: _____________Teacher: ____

The Champaign-Urbana Public Health District Children's Dental Clinic will visit your child's school to provide preventative dental services. ***This fulfills the State Mandate requiring all K, 2nd and 6th grade students to have a dental exam by May 15, 2011.*** *Dentists and Registered Dental Hygienists will provide these services in your child's school with portable equipment. PLEASE COMPLETE ALL OF THE INFORMATION REQUESTED BELOW, SIGN THE SIGNATURE LINE and RETURN TO THE SCHOOL if you would like your child to receive this service. You will receive a report after your child is seen. If you have questions, please call (217) 531-4279.*

PLEASE PRINT AND USE INK.

Child's name ___________________________ ☐ Male ☐ Female **Birth Date** ___/___/___ **Phone:** ____________________

Address ____ **City** __________________________ **ZIP** ______________________

Ethnicity (*optional*) ☐ Hispanic ☐ Non-Hispanic **Race** ☐ White ☐ African Am. ☐ Am. Indian/Alaskan native ☐ Other

1. Does your child have any medical history that may complicate dental treatment? ☐ Yes ☐ No **If "yes", please indicate below**:
   ☐ Previous or Planned Heart Surgery ☐ Asthma ☐ Blood Disorder ☐ Other_______________________
2. Does your child qualify for free or reduced school lunches? ☐ Yes ☐ No
3. Does your child receive Medicaid or All Kids? ☐ Yes ☐ No
   Medicaid or All Kids ID number (next to child's name on card) _____ _____ _____ _____ _____ _____ _____ _____ _____
4. Is your child covered by dental insurance other than All Kids? ☐ Yes ☐ No If yes, name of insurance: _________________________

PARENT OR LEGAL GUARDIAN MUST READ & SIGN BEFORE CHILD MAY PARTICIPATE

I give permission for Champaign-Urbana Public Health District Children's Dental Clinic to treat my child. I verify that I have read the back of this form regarding the privacy of health information (HIPAA). I give permission for the IL Department of Public Health to provide quality assurance audits of dental records. I also give permission for dental providers to return to my child's school and recheck my child's dental sealants.

Signature: X_______________________________ **Please Print Name:** ______________________________ **Date:** _____/_____/_____

DO NOT WRITE IN THIS BOX. This area to be completed by C-UPHD dentist.
---------------------------------CURRENT DENTAL STATUS OF PATIENT--

PRIOR RESTORATIONS
____
____
____
____
____
____
____

PRIOR SEALANTS
____
____
____
____
____
____
____

Caries Experienced _____YES _____NO
Sealants present _____ YES _____ NO
*Cavitated Lesion _____ YES _____ NO
Soft Tissue Pathology ____ YES _____NO
Malocclusion _____YES _____NO

ORAL HEATH SCORE

*At least ½ mm of the tooth structure loss at the enamel surface. Brown or dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries.
Broken or chipped teeth, plus teeth with temporary fillings are considered sound unless a cavitated lesion is also present.

TREATMENT NEEDED:

DECAY
____
____
____
____

SEALANTS
____
____
____
____

_____ URGENT (Must submit a referral sheet)
_____ Simple restorative (less than 5 fillings)
_____ Complex restorative (5 fillings or more, etc.)

TREATMENT COMPLETED:

_____ Preventative Dental Care Only, Including Sealants
_____ No treatment required
_____ Other: Periodontal or Orthodontic

_______EXAM
_______PROPHY
_______ Fl2

SEALANTS:
____
____

TREATMENT DATE: ____/_____/______

____ Date: ___/___/___
Reviewed HH & Provided Treatment (Signature of RDH)

____Date: ___/___/___
Reviewed HH & Provided Treatment (Signature of Dentist)