2022-23 SCHOOL DENTAL SERVICES CONSENT

Your student's school has arranged for the Champaign-Urbana Public Health District's Child & Teen Dental Clinic to provide dental services at school during the school day with **NO COST** to you.
Services are open to students in all grades who have Medicaid or All Kids, or who are uninsured.

Services include dental exam, dental sealants, cleaning and fluoride treatment to prevent cavities.
This meets the State of Illinois dental exam requirement.

Please complete the consent below for your student to be seen.

PRINT & USE AN INK PEN

STUDENT'S NAME_____BIRTHDATE_____

SCHOOL NAME_____GRADE___ GENDER _____ PRONOUNS_____

MEDICAL HISTORY

____ **NO KNOWN MEDICAL CONDITIONS**
____ ADD, ADHD OR RELATED
____ AIDS OR HIV POSITIVE
____ ASTHMA; *USES INHALER? ___YES ___NO*
____ AUTISM
____ BLOOD OR BLEEDING DISORDERS
*TYPE:*_____
____ 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 that 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. I give permission for my child to be seen by a Public Health Dental Hygienist (under the supervision of a licensed dentist).

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 2022-23 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** _____

PHONE NUMBER _____

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PARENT OR LEGAL GUARDIAN:

NAME _____EMAIL_____

ADDRESS _____ APT # _____ CITY _____ZIP CODE_____

STUDENT'S RACE & ETHNICITY:

RACE:

____ **Prefer not to answer** ____ **American Indian or Alaskan** ____ **Asian**

____ **Black or African American** ____ **Hawaiian or Pacific Islander** ____ **Other Islander**

____ **Hispanic or Latino** ____ **White**

Ethnicity:

____ **Prefer not to answer** ____ **Hispanic or Latino** ____ **Non-Hispanic or Latino**

INSURANCE:

NAME OF DENTAL INSURANCE:_____

STUDENT'S INSURANCE ID # ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

CHECK HERE IF **NO INSURANCE** ☐ **Please answer question below to determine eligibility.**

If no insurance, what is your monthly gross income? _____ What is your household size? _____

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----------**FOR OFFICE USE ONLY**----------

DENTIST'S SIGNATURE _____DATE _____

STUDENT'S NAME _____DOB_____ CHART # _____

TEACHER _____ ROOM # _____

ELIGIBLE FOR: ____ EXAM ____ FLUORIDE ____ SEALANTS