2019-20 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.

PRINT & USE AN INK PEN

STUDENT'S NAME _____ BIRTHDATE _____

SCHOOL NAME _____ GRADE _____ ☐ FEMALE ☐ MALE ☐ UNKNOWN

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: _____

_____ 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 2019-20 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 _____

TURN PAGE OVER AND COMPLETE OTHER SIDE

PARENT OR LEGAL GUARDIAN:

NAME _____ EMAIL _____

ADDRESS _____ APT#_____ CITY_____ ZIP CODE _____

STUDENT'S RACE & ETHNICITY:

RACE: **_____ Unspecified**

_____ Asian

_____Hawaiian or Pacific Islander

_____Other Islander

_____ Black or African American

_____ American Indian or Alaskan

_____White

_____ Hispanic / Latino

_____ Prefer not to answer

ETHNICITY: **_____ Unspecified**

_____ Hispanic / Latino

_____ Non-Hispanic / Latino

_____ Prefer not to answer

INSURANCE

_____ NO DENTAL INSURANCE _____ IL MEDICAID _____ BLUE CROSS _____ HARMONY _____ MOLINA

_____ MERIDIAN _____ OTHER: _____

STUDENT'S INSURANCE ID # _____ _____ _____ _____ _____ _____ _____ _____ _____

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

DENTIST'S SIGNATURE _____ DATE _____

STUDENT'S NAME _____ DOB _____ CHART # _____

STUDENT'S TEACHER: _____ ROOM #: _____