Webster County Health Department

Dental Screening, Fluoride Varnish, and Sealant Application Consent Form

Child's name (first&last)	Sex: □ M □ F	Parent's name (first& last)	Child's Age	Child's Date of Birth

Address: City & Zip Code:	Phone: I consent to the agency's use of email and texting to send me scheduling & child health services information. □ Yes □ No
Child's physician: Date of last appt:	Child's dentist: Date of last appt:
Medicaid number (if applicable):	Race: □ White □ Asian/Pacific Islander □ Hispanic □ Black □ Native American □ Other
Teacher's Name:	Grade: / School:

Medical Health History: *Please complete ALL information on this form*

1. Is your child under physician's care for any medical conditions? ☐ Yes ☐ No
2. Is your child taking any medications? ☐ Yes ☐ No
3. Does your child have any allergies to foods or medications? ☐ Yes ☐ No
   Please explain any YES answers above____
4. Is your child up-to-date on immunizations? ☐ Yes ☐ No
5. Is your child eligible for the free/reduced lunch program at school? ☐ Yes ☐ No

Dental Health History: *Please complete ALL information on this form*

1. Does your child have a regular dentist? ☐ Yes ☐ No
2. My child's last visit *with a dentist* was within the last: (check one)
   ☐ 6 months ☐ 12 months ☐ 3 years ☐ 5 years ☐ Has never seen dentist
3. How do you usually pay for your child's dental care? (check one)
   ☐ Self ☐ Medicaid (Title XIX) ☐ *hawk-i* ☐ Private Dental Insurance ☐ Other ______________________
4. Do you have any questions or concerns about your child's teeth or mouth? ☐ Yes ☐ No
   If yes, please explain: ____

______ **YES**, I give permission for my child to receive a dental screening, sealants and fluoride varnish application.
______ **NO**, I do not give permission for my child to receive a dental screening, sealants, or fluoride.

- I was offered a Notice of Privacy Practices.
- I understand that this consent is valid for one (1) year unless withdrawn in writing by the parent or guardian.
- I understand that the services received do not take the place of regular dental checkups at a dental office.
- I understand that these services are provided under the Iowa Department of Public Health, Maternal & Child Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health, Iowa Medicaid Enterprise or designee for audit and quality improvement purposes or other legally authorized purposes.

Sign here (consent)

Signature of Parent/Guardian **Relation to Child** **Date**

I voluntarily authorize Webster County Health Department to release, obtain or exchange information manually and/or via an electronic platform maintained by TAVHealth with the following: dentist, Head Start, school or preschool, New Opportunities, Upper Des Moines Opportunities, Local Public Health/ Community Health or Iowa Central Community College Dental Hygiene Program.
This release does *not* authorize disclosure of material protected by federal and /or state law applicable to substance abuse, mental health and/or AIDS-related information.

Sign again (release)

Signature of Parent/Guardian **Relation to Child** **Date**

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