

Smart Mouths

Smart Kids

Improving Dental Health for Colorado Students

## PARENTAL INFORMED CONSENT FOR DENTAL ASSESSMENT & LIMITED TREATMENT

Dear Parent or Legal Guardian,

Smart Mouths Smart Kids ("SMSK") is a free dental service that is coming to your child's school.

If you provide your informed consent for your child to participate, a dental hygienist will look at your child's teeth. She will clean your child's teeth, and brush on fluoride varnish to protect teeth from cavities, if needed. She will look at your child's back teeth and decide if they should have sealants. Sealants are plastic coatings that protect teeth from cavities.

The hygienist will send a form home with your child that tells you if your child has any dental problems and tells you how to contact a dentist in your area who will see your child for dental care.

If you want your child to participate in this program, please fill in the blanks:

Your child's FIRST name: \_\_\_\_\_

Your child's LAST name: \_\_\_\_\_

Female \_\_\_\_\_ Male \_\_\_\_\_

Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Address: \_\_\_\_\_

Name of School \_\_\_\_\_

Teacher \_\_\_\_\_

You may answer this question if you want to, but you are not required to answer. This information will only be used to determine that a diverse group of students is participating in SMSK.

Ethnicity: White \_\_\_\_\_ Hispanic/Latino \_\_\_\_\_ African American \_\_\_\_\_ Asian \_\_\_\_\_ American Indian/Alaska Native \_\_\_\_\_

Native Hawaiian/Pacific Islander \_\_\_\_\_ Other \_\_\_\_\_

Has your child ever had:

Allergies Yes \_\_\_\_\_ No \_\_\_\_\_ To what? \_\_\_\_\_

Asthma Yes \_\_\_\_\_ No \_\_\_\_\_

Heart problems Yes \_\_\_\_\_ No \_\_\_\_\_ If "yes," please explain: \_\_\_\_\_

Seizures or convulsions Yes \_\_\_\_\_ No \_\_\_\_\_

Allergy to latex YYes \_\_\_\_\_ No \_\_\_\_\_

Other serious health problems? Yes \_\_\_\_\_ No \_\_\_\_\_ If "yes," please explain \_\_\_\_\_

# Parental Informed Consent For Dental Assessment & Limited Treatment

What is the name of your child's doctor? \_\_\_\_\_

Do you have private dental insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Insurance Company name and policy number \_\_\_\_\_

Does your child have Medicaid? Yes \_\_\_\_\_ No \_\_\_\_\_

Medicaid ID number \_\_\_\_\_

Does your child have CHP+? Yes \_\_\_\_\_ No \_\_\_\_\_

CHP+ ID number \_\_\_\_\_

Does your child go to the dentist? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is the dentist's name? \_\_\_\_\_

When was the last time that your child went to the dentist?

Less than 1 year ago \_\_\_\_\_ 1 year ago \_\_\_\_\_ 2 years ago \_\_\_\_\_ more than 2 years ago \_\_\_\_\_ never \_\_\_\_\_

I have read all of the information in this form or I have had it read to me in a language that I understand.

I understand that a licensed dental hygienist will perform a dental screening on my child. The hygienist will also apply fluoride varnish and sealants if my child needs them.

I will receive a form that explains what the hygienist did and how I can obtain follow-up care for my child.

I understand that the hygienist will rely on the information I provided above in order to provide dental treatment to my child. All of the information I provided is correct.

I am my child's mother or father by birth or adoption, or my child's court-appointed legal guardian and I have authority to consent to dental treatment for my child.

I give my consent for my child to receive the dental treatment described above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Phone Number \_\_\_\_\_

\_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Legal Guardian

*PLEASE CHECK ONE:*

\_\_\_\_\_ *I give my permission*

\_\_\_\_\_ *I do not give my permission*

*for SMSK and my child's school to use photographs of my child to promote the SMSK program.*