



# Consent Form

## Treatment Agreement and Release of Liability Form

PLEASE PRINT CLEARLY

I hereby release, waive and discharge the DuPage County Health Department, their employees and agents, from any liability to me, my personal representatives or next of kin for any and all damage, and any claim or demands made on account of dental services provided. I further agree to indemnify, save and hold harmless the DuPage County Health Department and any of its agents from any loss, liability, damage or cost or claim they may incur as a result of dental services. I have read and understood this agreement and voluntarily agree to all of its terms and conditions. I understand that the DuPage County Health Department is providing these procedures as a public service and has my permission to recheck and replace sealants as dictated by the grant, this authorization expires five years from this date.

**I give consent for my child to have dental treatment by the DuPage County Health Department Dental Program.**

I hereby authorize the dentists and dental hygienists in attendance to examine and treat my minor or ward as applicable and to perform all dental procedures including local anesthesia, restorations, extractions, dental cleaning, sealants and fluoride treatment as may be deemed necessary by the dentist.

**I have reviewed my child's medical history.**

I understand that DuPage County Health Department may use and disclose protected health information about me in order to carry out treatment, payment and health care operations as well as for other reasons outlined in the Notice of Privacy Practices. Further, I understand that if applicable, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, AIDS, STD, and other privacy laws provide additional and in some cases stricter protections of my personal information. In no manner, does this acknowledgment reduce my privacy protection under the law.

**I permit the Department to use my protected health information as described in the Privacy Notice.**

**Sign Here:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender:  Male  Female Race: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ School: \_\_\_\_\_

How many people live in your household?: \_\_\_\_\_

**Please Circle Your Family Income:**

<b>\$39,440 or less</b>	<b>\$70,280 or less</b>	<b>\$93,298 or less</b>
<b>\$49,720 or less</b>	<b>\$80,560 or less</b>	<b>\$101,008 or less</b>
<b>\$60,000 or less</b>	<b>\$90,840 or less</b>	<b>\$108,718 or more</b>

**My child is eligible for the FREE or REDUCED lunch program:**  Yes  No

**If child has Medicaid:**

Enter Child's 9-digit Medicaid Recipient ID Number HERE:

Your Medicaid will be billed.

**Has your child ever had any of the following?: (Check Yes or No)**

Heart Condition  Yes  No    Seizures/Convulsions  Yes  No    Bleeding Disorder  Yes  No  
Tuberculosis  Yes  No    Diabetes  Yes  No    High Blood Pressure  Yes  No  
Asthma  Yes  No    Liver/Kidney Problems  Yes  No

Have you ever been told by a dentist or physician that your child needs to take antibiotics (Penicillin) before dental care?:  Yes  No

Does your child have Allergies?:  Yes  No    List Allergies: \_\_\_\_\_

Does your child take Medication?:  Yes  No    List Medications: \_\_\_\_\_

Does your child have any other health issues?:  Yes  No    List: \_\_\_\_\_



**PLEASE COMPLETELY FILL OUT AND SIGN THE ATTACHED CONSENT FORM  
AND RETURN TO YOUR CHILD'S TEACHER**

**The DuPage County Health Department Dental Program  
will be coming to your school to do dental exams for all  
children who return a completed signed consent form.**

- This dental exam will meet the state mandated requirement for Kindergarten, 2nd, 6th, and 9th graders.
- If the child meets the necessary requirements they will receive a dental cleaning, fluoride treatment, and sealants.
- A letter will be sent home with the exam results and what services were done.
- **BONUS: EVERY CHILD WILL RECEIVE A FREE TOOTHBRUSH!**



 **DUPAGE COUNTY  
HEALTH DEPARTMENT**  
DENTAL HEALTH SERVICES

 **(630) 682-7400**

