PARENTAL CONSENT / HEALTH HISTORY

If you are interested in obtaining dental hygiene treatment for your child at school with Brighter Smiles LLC, please indicate your consent by completing this form and returning it to your child's teacher.

I give permission for

Child's Name_____

Date of Birth _____ to be evaluated by the Dental Hygienist and to receive dental hygiene services consisting of screenings, evaluations, dental cleanings, fluoride treatments, sealants, oral hygiene instruction, as needed for as long as my child is enrolled at school or until I revoke this authorization. I may revoke this authorization anytime by submitting written notice of the withdrawal of consent to the school.

Home Address _____

School Name and Rm #_____

Parent/Guardian phone #_____

HUSKY Policy # _____

We will contact you to review this form prior to care and a report will be sent home with your child on the day of treatment.(For those without insurance or private insurance please email us at brightersmiles860@gmail.com or call 860-984-5794)

Name and phone # of primary care physician

_____

Medical History: Does your child have any history of the following? Please circle yes or no

Yes No Allergy to any medication or food? If yes, please list_____

Yes No Taking any medication regularly? (Please include inhalers) _____

Yes No Chronic health problems such as: **(please check all that apply)**

___Asthma ___Seizures ___Sickle Cell ___Eating issues

___Diabetes ___HIV/AIDS ___Learning Disability

___Behavior Disorder___ TB ___Cancer or chemotherapy ___ Abnormal Bleeding ___Autism Spectrum Disorder

___Heart Disease, Heart Murmur or Rheumatic Fever , Implanted medical device such as defibrillator or replacement joints (hip, knee)if yes, does he/she require premedication with antibiotics prior to dental treatment, please include what type and name of physician _____

Yes No Any other health issues you would like us to know about?_____

Yes No Has your child had any difficulty with dental visits in the past?_____

Yes No Does your child have any dental concerns you would like us to know about?

_____

Yes No You agree to keep us informed of any changes in your child's health by emailing us at brightersmiles860@gmail.com or call us at 806-984-.5794.

Yes No Brighter Smiles LLC has made available to me their Notice of Privacy Practice * (located on district website)

Yes No You agree that messages can be left on the phone # you provided above.

We will contact you to review this form prior to care and a report will be sent home with your child on the day of treatment.

Parent or Guardian's name (please print)_____

Parent or Guardian's signature _____Date_____

Emergency Contact

Name _____

Phone # _____

_____

Office use only

Form reviewed by _____ Date_____