DENTAL
CONSENT FORM

Dear Parent,

On behalf of the Shiocton Community School District, Tri-County Dental is offering an oral health program for children in your elementary school. The program includes: a dental screening, cleaning, x-rays, fillings and fluoride treatments and oral health education. A new toothbrush, toothpaste, and floss will be sent home with your child.

Please complete this form if you want your child to be part of the program:

***Child's Last Name**:______________________________________ ***First name**: ______________________________________

***Child's Date of Birth**:______-______-________ Female / Male Phone Number (_______) ________-__________

Child's Address:____ County: Calumet/ Outagamie/ Winnebago

School: _____________________________________ Grade in 2020-21 (circle): EC/PK K 1 2 3 4 5 6

Child's Race/Ethnicity (Check all that apply): _______White _______African American/Black _______Asian
_____Hispanic _____American Indian / Alaska Native ______Native Hawaiian / Pacific Islander _____Other

I understand the nature of the treatment provided and authorize the Tri-County Dental staff to provide oral health treatment.

- I acknowledge that Tri-County Dental may use my child's information for treatment and may disclose it to my insurance company and/or other health care providers even though it may affect future insurance claims.
- I understand that this permission is effective for a period of twelve months in order to provide follow-up services, including restorative treatment, dental cleaning, application of sealants and multiple fluoride applications which may include silver diamine fluoride (used to stop cavities from progressing).
- I understand that my child's restorative treatment plan, if necessary, will be provided to me prior to the treatment starting.
- I am authorizing Tri-County Dental to use nitrous oxide if needed for the completion of dental treatment.
- I agree to the release of my child's treatment plan records so I can receive them from the school.
- I am specifically authorizing the clinic to treat my child whether or not I am physically present at the clinic during a scheduled treatment.

My signature will confirm my informed consent, my status as the legal custodian of the minor patient identified and my authority to grant this consent. I understand that I may contact Tri-County Dental at 920-882-5500 if I have questions.

___________________________________/_______________________________________ Date ____/_____/______
(Print) parent/guardian **(Signature) parent/guardian**

Does your child see a dentist on a regular basis (every 6 months)? YES / NO

Does your child have allergies to Colophony resin? YES / NO

Does your child have Medicaid (Medical Assistance, BadgerCare, Title 19)? YES / NO

MA Number________________________

Does your child have private dental insurance? YES / NO

Name of Dental Insurance Company ____

(OFFICE USE ONLY)

***Verbal permission for Phase 1** ☐ **Signature of School Administrator**____________________________________