Community Health Connections
Caring for Kids

☐ **YES** I give my permission for my child to participate in the **Caring for Kids Dental Program.**
I understand that my child may receive the following as part of the program: dental exam (2x in school year), fluoride varnish (3x in school year), dental cleaning (2x in school year) and dental sealants (as needed).
I give my permission for X-rays to be taken as needed ☐ YES ☐ NO

School: _____ Grade: _____ Teacher/Homeroom: _____

CHILD INFORMATION (PLEASE PRINT):

Child's Last Name: _____ First Name: _____ Birthdate: _____

☐ Male ☐ Female ☐ Other Parent's Name: _____

Address: _____ City: _____ State: _____ Zipcode: _____

Parent's Daytime Phone #: _____ Parent's Email: _____

What language does *your child* speak best? _____ What language does parent speak best? _____

What is *your child's* race? ☐ Asian ☐ Black/ African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White
☐ American Indian/ Native American/ Alaska Native ☐ Other: _____

What is *your child's* ethnicity? ☐ Hispanic/Latino ☐ Not Hispanic/Latino

What is *your child's* current housing status: ☐ Own or Rent ☐ Doubled Up ☐ Transitional Housing ☐ Homeless shelter
☐ Street (living in a private or public place not usually used for sleeping – ex: car, park, abandoned building or bus/train station

Is *your child's* housing status: ☐ Section 8 ☐ Public Housing ☐ Not Public Housing

HEALTH INFORMATION (PLEASE PRINT):

Is your child taking any medications? ☐ No ☐ Yes (please list): _____

Does your child have any allergies? ☐ No ☐ Yes (please list): _____

Does your child need to take antibiotics *before* having dental treatment? ☐ No ☐ Yes*

**If yes, please tell us the reason for pre-med and which antibiotic your child takes:* _____

Has your child EVER had an illness or condition? ☐ No ☐ Yes – *please check all that apply*:

☐ ADD/ADHD ☐ Anemia ☐ Asthma ☐ Diabetes ☐ Epilepsy/Seizures ☐ Heart Condition: _____

☐ Hepatitis ☐ HIV/AIDS ☐ Kidney/Liver Disease ☐ Rheumatic Fever ☐ TB ☐ Other: _____

Does your child have a dentist? ☐ No ☐ Yes – Last visit: _____

Does your child have Dental Insurance? ☐ No ☐ Yes – *Please complete below*:

Dental Insurance Company Name: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID #: _____ Group Policy #: _____

Employer's Name: _____

I understand that Caring for Kids may use my child's information for treatment, payment and healthcare operations. I have been offered a copy of the Notice of Privacy Practices. I have read and understand the dental program and services and I consent to have my child participate in the program. I authorize Caring for Kids to provide a written summary of the services provided to my child and to an official designated by my child's school. I understand that my child may continue to receive services from another provider. If I have dental insurance, I acknowledge that these services may affect my future rights and insurance benefits, and I authorize my insurance carrier to be billed for any services provided.

X_____ Date: _____ Relationship to Child: _____

Parent/Guardian Signature (if completing paper copy)
(Typing your name is your electronic signature for consent)