SCHOOL-BASED DENTAL PREVENTIVE SERVICES PROGRAM CONSENT FORM
DIVISION OF PREVENTION AND HEALTH PROMOTION - VIRGINIA DEPARTMENT OF HEALTH

DIRECTIONS: Please complete this form and return it to the school within 3 days in the enclosed envelope. Please be assured that your answers will be kept confidential.

School: _____ Teacher's Name: _____ Grade: _____

Student's Name: _____
Last First Middle Initial

Student's Age: _____ Student's Date of Birth: _____ Student's **Sex: M___ F___**

Of the following, which best describes your child? Please check only one.

☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Asian or Pacific Islander
☐ American Indian or Alaska Native ☐ Hispanic ☐ Other/Multiracial

Is your child currently under a physician's care for a medical condition? ☐ Yes ☐ No
Is your child currently taking any medications? ☐ Yes ☐ No
Has your child ever had any allergic reactions? ☐ Yes ☐ No
Has your child ever had any heart problems or valve surgery? ☐ Yes ☐ No
Has your child ever required premedication for dental care? ☐ Yes ☐ No
Does your child have a special health care need? ☐ Yes ☐ No

Please explain any **"Yes"** answers: _____

Does your child have dental insurance? ☐ Yes ☐ No If yes, list provider _____

Does your child have Medicaid? ☐ Yes ☐ No

Does your child participate in the free lunch program? ☐ Yes ☐ No

Does your child see a dentist yearly? ☐ Yes ☐ No If yes, please consult your dentist for services; this program is intended for children without a family dentist or regular dental care

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Please check the boxes below to give your permission

By signing below, I verify that I give permission for my child to receive the services listed below and I understand following Covid-19 pandemic protocols my child may have their temperature checked before treatment is provided.

☐ Dental Sealant Services- I understand the services include screening and dental sealants provided by a licensed dental hygienist with the Virginia Department of Health (VDH). Next school year my child will have a follow up visit to check and repair their sealants if needed.

☐ Dental Cleaning Services – I understand the services include scaling to remove calculus (tartar), if appropriate for the child. The cleaning will be provided by a licensed dental hygienist with VDH, if this service is approved by your school principal.

☐ Dental Varnish Services- I understand the services include screening and a preventive fluoride application, if appropriate, for the child. The fluoride application will be provided by a licensed dental hygienist with VDH.

Parent's Name (Print): _____

Parent's Signature: _____ Date: _____

Address: _____

Home Phone Number: _____ Cell Phone Number: _____

No payment is required from you for your child to participate in this program. However, Medicaid and SCHIP insurance help cover the costs of the program. If your child is insured through Medicaid, please complete the form labeled *For Students with Medicaid.*

For the Virginia Department of Health privacy policy visit: www.vdh.virginia.gov/privacy-policy/