Protecting All Smiles
Public Health Dental Hygiene

Protecting All Smiles, LLC Program Consent/Medical History Form

Please complete (in ink) and return to your child's teacher tomorrow

Child's Name_____ **Date of Birth**___/___/____ **Male**__ **Female**__

Address: Street_____ **Apt**_____**City**_____**State**____

Parent/Guardian Email Address_____ **Child's Grade** _____

___YES, I give permission for my child to participate
___NO, I do not give my child permission to participate

Does your **child have any allergies?** If **yes**, please check all that apply:
Colophonium___ **Latex**___ **Tree Nuts**___ **Resins**___ **Foods**___ **Red Dye**___ **Other**_____

General Information:
What language does the parent speak at home?_____
What is your child's race?
American Indian/Alaskan Native___ Asian___ Black/African American___ Hispanic/Latino___
More than one___ White___ Other___

Health Information:
Does your child see a doctor for regular checkups? Yes___ No___
Does your child see a dentist for regular checkups? Yes___ No___
If yes, dentist name_____ Date of last dental visit_____

Is your child taking any medications now? If yes please list _____
Has your child **EVER** had an illness or condition? If yes please check all that apply:
ADD/ADHD___ Diabetes___ Epilepsy/Seizure___ Asthma___ Heart Conditions/Heart Murmur___
Other_____

Does your child have dental insurance? If **yes** please complete below: Yes__ No__

Mass Health/Medicaid ID Number:

____/____/____/____/____/____/____/____/____/____/____/____

I understand that this consent will stay in effect for two years. If dental sealants are placed they will be rechecked and reapplied next year if needed. It is the parent/guardian's responsibility to inform the dental provider of any changes in their child's medical information. I understand that a copy of my child's dental report may be given to the center and that all the information about my child will be kept confidential. If I have dental insurance, I authorize my insurance carrier to be billed for any services provided. I have been given a copy of the Protecting All Smiles, LLC Notice of Privacy Practices. I have read and understand the dental program and I consent to have my child participate. I understand that these services do not substitute an examination by a dentist. I understand that my child should obtain an examination by the dentist within 90 days. I authorize the dental program to forward any referrals to my child's dentist of record when applicable.

X_____ **Date**____/____/____ **Relationship to Child**_____
Parent/Guardian Signature

Print Name_____ **Phone Number**_____

Contact Information: Elizabeth Chouinard, RDH (774)-930-2052 Carol Gilmore, RDH (508)-326-1864