



**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:

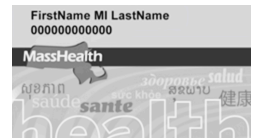
ADD/ADHD\_\_\_ Diabetes\_\_\_ Epilepsy/Seizure\_\_\_ Asthma\_\_\_ Heart Conditions/Heart Murmur\_\_\_

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