Consent and Release of Information

Child's Name:		Age:	Date of Birth:
Address:		Cell Phone: Other Phone:	
☐ Male ☐ Female	Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ Native American ☐ Other ☐ Undetermined / Unknown		
School:	Teacher's Name:	Grade:	
Child's Physician:		Child's Dentist:	
If applicable, child's Medicaid ID Number:			

_____ **YES**, I give permission for my child to receive a dental screening, sealants, and fluoride varnish application.
Please answer the following questions:

1. Is your child currently under a physician's care? ☐ Yes ☐ No
2. Is your child currently taking any medications? ☐ Yes ☐ No
3. Does your child have any allergies? ☐ Yes ☐ No

Please explain any YES answers: _____

_____ **NO**, I do not give permission for my child to receive a dental screening, sealants, and fluoride varnish application.

1. Does your child have a regular dentist? ☐ Yes ☐ No
2. If yes, does your child see that dentist at least once a year? ☐ Yes ☐ No
3. Is your child eligible for the free/reduced lunch program at school? ☐ Yes ☐ No
4. My child's most recent dental visit was within the past: (please check one)

☐ 6 months ☐ 12 months ☐ 3 years ☐ 5 years ☐ has never seen a dentist

5. How do you pay for your child's dental care? (please check one)

☐ Self ☐ Medicaid/Title XIX ☐ ***hawk-i*** ☐ Private dental insurance ☐ Other

6. List any concerns you have about your child's mouth or teeth? _____

I consent to the agency's use of email and texting to send me scheduling and child health services information.
☐ Yes ☐ No

- I was offered a Notice of Privacy Practices.
- I understand that this consent is valid for one (1) year unless withdrawn in writing by parent or guardian.
- I understand that the services that will be received do not take the place of regular dental checkups at a dental office.
- I understand that these services are provided under the Iowa Department of Public Health, Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health, Iowa Medicaid Enterprise, or designee for audit and quality improvement purposes or other legally authorized purposes.

Parent/Guardian Signature **Date**

I voluntarily authorize Johnson County Public Health to release, obtain, or exchange information with the following: physicians, dentists, and school .
This release does *not* authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health, and/or AIDS-related information.

Parent/Guardian Signature **Date**