Consent Form

Treatment Agreement and Release of Liability Form

DUPAGE COUNTY HEALTH DEPARTMENT
DENTAL HEALTH SERVICES

PLEASE PRINT CLEARLY

First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____ / _____ / _____ Gender: ☐ Male ☐ Female Race: _____

Parent/Guardian's Name: _____

Address: _____ City: _____ Zip Code: _____

Home Telephone Number: _____ E-mail: _____

Grade: _____ Teacher: _____ School: _____

How many people live in your household: _____

Please Circle Your Family Income:

$0 - $43,280	**$77,360 or less**	**$111,440 or less**
$54,640 or less	**$88,720 or less**	**$122,800 or less**
$66,000 or less	**$100,080 or less**	**$134,160 or more**

My child is eligible for the FREE or REDUCED lunch program: ☐ Yes ☐ No

Enter Child's 9-digit Medicaid Recipient ID Number HERE:

Does Child Have Medicaid? ☐ Yes ☐ No ☐☐☐☐☐☐☐☐☐ **Your Medicaid will be billed.**

Has your child ever had any of the following?: (Check Yes or No)

Heart Condition ☐ Yes ☐ No Seizures/Convulsions ☐ Yes ☐ No Bleeding Disorder ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No Diabetes ☐ Yes ☐ No High Blood Pressure ☐ Yes ☐ No

Asthma ☐ Yes ☐ No Liver/Kidney Problems ☐ Yes ☐ No

Does your child have Allergies? ☐ Yes ☐ No List Allergies: _____

Does your child take Medication? ☐ Yes ☐ No List Medications: _____

Does your child have any other health issues? ☐ Yes ☐ No List: _____

Have you ever been told by a dentist or a physician that your child needs to take antibiotics (Penicillin) before dental care? ☐ Yes ☐ No

Sign Here: _____ **Date:** _____ / _____ / _____

I hereby release, waive and discharge the DuPage County Health Department, their employees and agents, from any liability to me, my personal representatives or next of kin for any and all damage, and any claim or demands made on account of dental services provided. I further agree to indemnify, save and hold harmless the DuPage County Health Department and any of its agents from any loss, liability, damage or cost or claim they may incur as a result of dental services. I have read and understood this agreement and voluntarily agree to all of its terms and conditions. I understand that the DuPage County Health Department is providing these procedures as a public service and has my permission to recheck and replace sealants as dictated by the grant, this authorization expires five years from this date. IDPH to conduct scale and retention checks for up to 365 days post-service.

I give consent for my child to have dental treatment by the DuPage County Health Department Dental Program.

I hereby authorize the dentists and dental hygienists in attendance to examine and treat my minor or ward as applicable and to perform all dental procedures including local anesthesia, restorations, extractions, dental cleaning, sealants and fluoride treatment as may be deemed necessary by the dentist.

I have reviewed my child's medical history.

I understand that DuPage County Health Department may use and disclose protected health information about me in order to carry out treatment, payment and health care operations as well as for other reasons outlined in the Notice of Privacy Practices. Further, I understand that if applicable, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, AIDS, STD, and other privacy laws provide additional and in some cases stricter protections of my personal information. In no manner, does this acknowledgment reduce my privacy protection under the law.

I permit the Department to use my protected health information as described in the Privacy Notice.

We Drive Miles To Make Smiles

The SmileSquad

DuPage County Health Department

PLEASE COMPLETELY FILL OUT AND SIGN THE ATTACHED CONSENT FORM AND RETURN TO YOUR CHILD'S TEACHER

The DuPage County Health Department Dental Program will be coming to your school to do dental exams for all children who return a completed signed consent form.

- This dental exam will meet the state mandated requirement for Kindergarten, 2nd, 6th, and 9th graders.
- If the child meets the necessary requirements they will receive a dental cleaning, fluoride treatment, and sealants.
- A letter will be sent home with the exam results and what services were done.
- **BONUS: EVERY CHILD WILL RECEIVE A FREE TOOTHBRUSH!**



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(630) 682-7400

