TEXAS Health and Human Services | Texas Department of State Health Services

Grade: _____

Teacher: _____

For Internal Use Only

Oral Health Improvement Program
Parent Permission Form

The Texas Department of State Health Services (DSHS) will be at your child's school this year to give students a **FREE LIMITED DENTAL EVALUATION**. The information collected from this visit helps health officials understand and plan for the dental needs of children in your area. Qualifying students may also receive the following preventive services at no cost:

- Fluoride Varnish - a clear, protective coating to prevent new cavities. Helps stop the progression of small cavities.
- Dental Sealants - a thin, tooth-colored coating painted into the deep pits and grooves of the chewing surfaces that are hard to clean.

Please check the appropriate box below. If Yes, complete the entire form and sign.

☐ **YES**, I give permission for my child to receive a limited dental evaluation and recommended preventive services unless otherwise marked here: ☐ **No** Fluoride Varnish ☐ **No** Dental Sealants

☐ **NO**, I do not give permission for my child to receive any free dental services

Child's Name (first, last): _____ Age: _____

Date of Birth (mm/dd/yyyy): _____/_____/_____

Parent/Guardian's Name (first, last):

_____

City: _____ Zip Code: _____ Phone Number: (_____) _____-_____

Sex of Child: ☐ Male ☐ Female

Race/Ethnicity of Child: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other

Dental Insurance of Child: ☐ Private ☐ Medicaid ☐ CHIP ☐ Uninsured

Is your child in the Free/Reduced Lunch Program at school? ☐ Yes ☐ No

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☐ **Yes** ☐ **No** Is your child currently taking any medicine? If yes, please list current medications:

_____

☐ **Yes** ☐ **No** Is your child allergic to latex?

☐ **Yes** ☐ **No** Is your child allergic to any medicine? If yes, please list medication allergies:

_____

☐ **Yes** ☐ **No** Does your child have any serious illnesses? (Circle all that apply)

Asthma/Breathing Problems Heart Disease Hepatitis Bleeding Disorders

High Blood Pressure Epilepsy/Seizures Other:

_____

☐ **Yes** ☐ **No** Has your child's doctor ever told you your child has a learning, physical, and/or behavioral condition? If yes, please explain: _____

☐ **Yes** ☐ **No** Has your child ever been to the dentist for any reason?

☐ **Yes** ☐ **No** In the past 12 months, has your child seen a dentist for a routine dental checkup?

If yes, please list the name of dentist/office:

_____

By signing below, you give permission for your child to take part in the DSHS preventive dental clinic. And you are aware the limited dental evaluation does NOT replace regular dental checkups. You should keep taking your child to the dentist for regular dental checkups at least twice a year. We keep names confidential. Please also review and

sign the attached Notice of Privacy Practices Form. If you have any questions about the clinic, contract your school nurse or call the DSHS Oral Health Improvement Program at (512) 776-2008.

Parent/Guardian Signature: _____ Date: _____